GENERAL PRINCIPLES OF PSYCHOTHERAPY [1]

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Psychotherapy is part of medical practice. As with any useful medical procedure it should not remain limited to the specialist's office. Like all medical procedures, psychotherapy contains elements of art as well as of science.

In the practice of psychotherapy actions and attitudes are frequently more important than words. Emotionally sick adults have a good deal in common with children; in particular the facts that their complaints and abnormal actions frequently express their feelings and problems in a symbolic rather than a direct manner, that they frequently distrust words, that they learn more from example and the opportunity to identify themselves with good leadership than from precept, and that they relate themselves to the world more through emotional experience than according to instruction. Thus how the doctor acts toward the patient, how he listens and speaks to him is often more important than what he tells the patient. It is frequently of greater value to offer new good interpersonal experiences than new thought content, although both are inextricably interwoven.

Quite apart from its verbalizations, psychotherapy has an important elemental and nonverbal aspect. In its most elemental and nonverbal form, psychotherapy can be carried out successfully even on animals. Translated into the terms of the animal trainer, Pavlov(1) (see also Konorski(2)) in his work on experimental neuroses essentially found that dogs with weak nervous systems must be built up; those with "strong but unbalanced nervous systems" must be first broken or "reduced," such as by sedative medication, and then built up. It is obvious that, in treating animals, attitudes and actions play the main part, since animals do not understand words. But the ability to influence animals or human beings by attitudes and actions is the most important natural gift of the psychotherapist.

If I were asked to devise a screening test by which candidates gifted for psychotherapeutic work could be discovered, I would say that the type of person most likely to become a good psychotherapist was the one to whom stray dogs take easily, who could effectively gain the confidence of beaten dogs, or who could easily ride an anxious horse that was sensitive to the bit and that customarily shied at the slightest provocation. I would place much more emphasis upon these faculties and attitudes which are inherent as well as acquired than upon theoretic psychodynamic knowledge. It is important to be aware of these nonverbal and not primarily formularized attitudes. Some people have them as a natural gift, but they can be developed on the basis of awareness of their importance and a scientific study of the way in which they facilitate successful work. The psychotherapist must constantly keep in mind that his actions and his attitudes are at least as important as his words.

Once the principle has been understood the techniques can be learned. They are essentially: (1) supportive treatment; (2) ventilation; (3) abreaction; (4) shift of emphasis; (5) interpretation. Additional specialized subdivisions which are not recommended for general use but mainly for specific situations and conditions are: (6) suggestion and persuasion, and (7) reassurance. It is of particular importance, of course, to know the limits of these various forms of psychotherapy, and to know when to add other methods such as medicinal treatment or the various forms of shock therapy.

1. *Supportive Treatment.*—Here the main element is the doctor's attitude. Irrespective of whether the patient comes with a physical ailment or with a neuropsychiatric disease manifested by physical complaints, it is of fundamental importance that the doctor listen to the complaint, take it seriously, and

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subject the patient to a thorough physical examination. The thoroughness of an examination is frequently the main element of successful supportive treatment. The effect of such treatment is of course enhanced by the doctor's reputation in the community, by his standing as a professional man and citizen. Both a doctor's reputation and his thoroughness enhance each other; conversely, it can sometimes be disastrous if a well-qualified and highly respected man takes the complaint of the patient lightly and because of his initial impression and shortage of time subjects the patient to a merely hurried and superficial examination. This can increase the feeling of rejection which may be the main factor in the neurosis of an unsuccessful man or a rejected, unloved woman or child. The doctor must give, by his attitude and actions, the assurance to the patient that he cares for him, is interested in him, and is eager to help him. There is an old saying to the effect that "a specialist is a man who does a rectal examination." I should like to paraphrase this and say that a psychotherapist is a physician who takes a complete and thorough history and who does a complete and thorough examination.

The degree to which such an attitude is psychotherapeutic was recently brought home to me by a patient who consulted me in a state of severe anxiety.

This 46-year-old man complained of extreme nervousness, sweating, pains throughout all bones of his body and attacks of weakness lasting several days at a time. He was very anxious and tense and was sweating profusely. He sat with his arms tightly pressed to his body. On the examining table his muscles seemed to be in a state of tension, and he had difficulty in relaxing them. He showed a markedly increased startle response, while all spontaneous motor activity was greatly reduced. It may be that I subjected this man to a particularly thorough neurological examination because I wanted to be sure to find or rule out the evidence of an organic neurological condition, since this man had been subject to a blast injury; but the inadvertent psychotherapeutic effect of this detailed and painstaking examination was both surprising and delightful. As the examination progressed the patient gradually relaxed, and after it was over he was not only at ease, but cheerful and smiling. He departed in a state of apparent well-being. He said, "Doctor, thanks; you have done wonders for me. I have never had a check-up like that in my life." Without any direct psychotherapy this acute anxiety state, obviously caused by the fear of having been seriously injured, melted under the impact of a thorough, sympathetic, careful examination which was terminated by an encouragingly worded verdict of physical well-being. If this verdict had been rendered after a less painstaking examination it may very well have aroused resentment and antagonism, followed by a build-up of anxiety and further discouragement.

The same is true for other acute situational anxiety reactions, regardless of whether they express themselves in fear of injury by a serious accident, a fear of heart disease, or any other physical ailment. The verdict of physical health will be acceptable to such patients only if they have been subjected to an examination which is accepted by the patient as being of sufficient thoroughness, and the doctor must express by his attitude the fact that he has an open mind and is interested in finding out the truth.

This illustrates the important fact that part of psychotherapy is teaching, and the most effective way of teaching, as with children, is by example. If you want the patient to have an open mind and accept the truth, you must first show him that you have an open mind and are interested in the truth yourself. If you have a good relationship with your patient, he will unconsciously imitate your own attitude. The arousal of mimesis is indeed the most important instrument of successful teaching as well as of successful psychotherapy. Of course I do not mean to say that such reassurance can overcome a severe, deeply-ingrained anxiety neurosis or a prepsychotic panic, but an attitude of a wide-open mind and thoroughness will be helpful even in those conditions, although it may be wise to withhold reassurance and interpretation until the patient himself is ready to accept them. Again it is important to know one's limits. Unless you are very sure that the patient is ready to accept reassurance and interpretation, both of which are double-edged swords which have to be used with great caution, as will be pointed out later, it is much better to help the patient to stumble upon the solution by merely helping him with an attitude of thoroughness, open-mindedness, and interest in the true state of his health. It is important to realize that reassurance is not always real support. The anxious patient who deep inside believes that he is sick, dangerously sick,

will more frequently regard reassurance as a brush-off and a lack of real interest on the part of the physician.

I once treated a young woman with a severe phobic state which had many features of an early schizophrenic psychosis with obsessive features. Nevertheless there was a great deal of meaningful material which prompted me to go on with psychotherapy. This young woman had been to many doctors including psychiatrists, and had left them all after a few visits. After a long course of treatment with many ups and downs, she finally became well 15 months later. I then asked her, as I frequently do of recovered patients, what in her opinion was the most decisive therapeutic act to which she ascribed her recovery. She said, "When I went to you for the first time I did not like you and I almost did not want to come back. When I came the second time I asked you a question, namely whether I was actually out of my mind. I had that fear that I was going crazy or had actually gone crazy. When I asked you that you said 'I don't know. We have to find out first and then do the right thing about it.' That gave me confidence in you. All the other doctors I had been to told me that I wasn't out of my mind and that I wasn't going to lose my mind, and I thought that they didn't understand me or they didn't tell me the truth. When you told me that you didn't know, I knew that I could have confidence in you, that you were honest, and that you would always tell me the truth. From then on I kept coming back and I got well."

The answer I gave this patient had actually been the truth. I was impressed with the diagnostic problem and, even after putting her through the Rorschach and other tests, I wasn't quite sure whether this was not an acute schizophrenic development which might better be treated with electroshock or insulin. Certain tests were equivocal, especially the Rorschach, but the Cameron test and other thinking tests revealed the absence of a schizophrenic thinking disorder. This after a number of interviews finally threw the weight of evidence in favor of a condition modifiable by psychotherapy, which turned out to be effective after some time. I knew it was the ring of truth in my statement which carried the weight.

It is important to realize that emotionally sick people like children have an uncanny sense of truth. This is particularly important in dealing with children. The ability of children to look through and size up their parents and others close to them is frequently equal to that of trained psychologists and psychiatrists. True supportive therapy can therefore never be given without the solid foundation of conviction of truth in what the therapist is saying. In supportive treatment you must definitely show that you are on the side of the patient in his battle with the world.

2. *Ventilation.*—Next in importance is to give the patients full opportunity and the setting of understanding approval in which they can freely ventilate their stresses and emotions. Once the patient is started in successful ventilation, the physician should interrupt as little as possible, merely sitting there with the understanding and encouraging smile of the statue of a wise Buddha. This technique is particularly helpful in certain cases of anxiety hysteria as well as in the anxiety states of the older age groups, especially those with hypertension.

A good example of the former type is the case of a young married woman, aged 35 years, who came to my office accompanied by her younger sister in a state of marked distress and agitation, complaining of severe and persistent pain in her left cheek. She held her hand pressed against her left cheek, stating that as soon as she released the pressure the pulsating became unbearable. She asked the doctor to put his hand over her left cheek and feel the pulsating. This constant throbbing pain had been present for 3 years and she had consulted a good many doctors. At first she went to a dentist who searched in vain for an abscessed tooth and then referred her to a neurosurgeon. Her pain continued unabated, and one-half year later the patient consulted another neurosurgeon. After complete studies were negative, this neurosurgeon referred the patient to another dentist, who removed a number of teeth. Pain, however, continued without letup. Two weeks before referral to me, patient went back to her first dentist, who took out one additional tooth, which brought about no improvement. She was then referred to an otolaryngologist who found no physical abnormalities which could be causing her complaint, and referred her for neuropsychiatric examination. Patient added that her pain frequently made her depressed and frequently caused her to cry. Then she stated that this pain might be due to "something terrible" she had done in early life and that she had a guilty conscience which "bangs in the back of my mind." She then began to tell the grim history of her life and continued to do so for 16 consecutive visits, with very little interruption on my part except for occasional questions to keep the thread of her story in meaningful channels and to indicate understanding encouragement for her own struggle for insight. In the psychotherapeutic discussions I completely refrained from giving any interpretation, but instead merely helped patient by occasional questioning to find the meaning of her symptoms herself. After the sixth interview her pain was gone, and recurred later only on two occasions for brief and meaningful periods after the twelfth interview. It remained absent after the thirteenth interview and did not recur at any time within 3 years after the sixteenth and final psychotherapeutic session.

An equally striking reaction to purely ventilative

treatment occurred in a man aged 46 years who suffered from a chronic anxiety state with mild hypertension and symptomatic alcoholism. He had previously been refused insurance because of hypertension. When I first examined him his blood pressure was 175/80. His wife had been on the verge of leaving him because of his drinking. Psychotherapy in this patient remained entirely ventilative and consisted of 17 sessions extending over 6 months with a thorough ventilation of both early and recent life situations. It appeared that this patient derived particular benefit from the opportunity to "blow off steam" regarding his resentment against his employers and business associates. There was a remarkable gradual diminution of his anxiety as well as his hypertension. After 3 months of treatment, this patient's anxiety became sufficiently diminished that he felt able, without of course any implication of advice on my part, to take a step which he had wanted to take for many years, but had never quite dared to, namely to resign from his organization and to go into business for himself. Since then his blood pressure readings have remained consistently normal, namely 130/65. His symptomatic indulgence in alcoholic beverages likewise subsided, and he remained well and congenial with his family.

3. *Abreaction.*—It can be frequently observed when ventilation proceeds on a purely intellectual level without associated emotional expression that the therapeutic benefit is minimal or absent. Such patients may tell their story and at the end they may say, "This is my story, Doctor, but what does telling it do for me? I still feel the same way." It is then that you must bring about real emotional participation, an emotional reliving of the stress situation for which the word abreaction has come into vogue, which literally means to react off or to blow off steam.

There are various ways to bring this about. One way is to go over the ground again, and by one's attitude, without direct urging, prompt the patient to give true vent to his emotions. The most important part of the attitude is to imply approval of a marked show of emotion. Sometimes the use of drugs, such as barbiturates, ether, or benzedrine sulfate and its derivatives, or of special procedures such as hypnosis, has been useful in bringing about this needed reliving and working out of the emotional aspect of the experience. This has been particularly helpful in dealing with recent stress such as that occurring during war experiences or other crushing-threatening events to which an individual may be exposed (Sargant and Slater(3)). It has been particularly helpful in those patients who react to such experiences with a profound state of inhibition. This inhibition can be successfully broken by the administration of the drug. There is of course nothing particularly new about this. It is an old experience that alcohol frequently accomplishes this result, and it is true that many sick people abreact themselves quite inadvertently by alcohol, but the effect can be produced more readily and more controllably by intravenous barbiturates. Of course it is important to realize that barbiturates, ether, or whatever other drugs may be used do not act in any specific way except in that they release cortical inhibitions. The drug has in itself nothing to do with the emotional response, which is in part provoked by the strong and still-threatening stresses of the life situation, for instance, the imminence of the return to combat. All of us who have carried out abreaction treatment during the war and who have later attempted to repeat it in a peacetime setting at home have been impressed with the marked differences between the rich emotional responses obtainable in the wartime setting overseas and the scant responses obtainable now, more than 4 years after the traumatic setting. This has limited the use of this particular method for peacetime neuroses in which we deal with far less overwhelmingly threatening situations. It also confirms the fact that emotional content determines the intensity of the abreaction and that the release of the cortical inhibition by a barbiturate or other drug is merely one of the trigger mechanisms to set off the explosive charge which has to be detonated in order to free the personality. The important thing is to allow the emotional experience to be relived and to remove the inhibition of thinking and feeling.

Additional interpretation on the part of the therapist in working out the experience is sometimes of entirely secondary importance. I have seen severe inhibitory neurotic reactions relieved by narco-abreaction even before the "synthesizing" treatment could be started, merely by the release of the tremendous emotional experience alone. Looked at in Pavlovian terms, one may regard this abreactive experience as a strong

emotional stimulus which irradiates over the entire personality and frees the ego from its inhibitory state. The greater the emotional charge attached to the traumatic material, the more readily emotional participation is bound to be forthcoming when it is ventilated. It is probably for that reason that traumatic sexual material when worked through with a patient is bound to give particularly dramatic abreaction and result in relief because of the marked emotional charge commonly attached to sexual matters. The same is true for long-suppressed rivalries and hatreds, especially within the family circle.

I recall a patient aged 53 years who suffered from a severe anxiety state of 8 months' duration which started rather acutely when patient had to stop his car because he felt as though he could not go any further. He stopped at a gas station for a glass of water, where a man told him this could be a heart attack. Since then he had felt excited, nervous, frequently distressed or jumpy, especially when driving or riding in a car or plane, and would suddenly be overcome by the feeling that he never would arrive at his destination. This was always combined with a choking feeling as if he could not get air. Patient told his life history in a rather detached manner, including his long years of exploitation and deprivation by his father and brother. I saw him 3 times before being able to get any rise out of him. In the fourth interview I finally succeeded in making him blow off steam. This greater responsiveness had been aided by fortunate circumstance. On that day patient had suffered another anxiety attack shortly after seeing his brother, who after briefly inquiring about his illness told him curtly to snap out of it. This remark and the patient's resentment offered a starting point to make him abreact about his brother and others connected with his emotional stress. With very little prodding the patient then told the real story of his long-time resentments against his father and brother, vividly describing how he had taken it on the chin for many years, ever since his childhood. Patient cried at the termination of this interview, sobbed, abreacted thoroughly but not demonstratively at all, still rather trying to hold himself in. After it was all over he stated with a brightened-up face, "I feel better." When seen again a week later, he appeared greatly improved. He stated, "All last week I have been feeling better than I have felt for a long time. Today I feel perfect. Very good." His past history was then briefly reviewed again, patient reiterating that he had a lot of accumulation of all kinds of things which he had to take on the chin. After bringing it all out on the last interview, he had decided not to worry about these things any more. "That talk with you did me a lot of good. I feel I have brought something out. I gave something out that I have held in. That did me a lot of good. It was the first time I cried in I don't know how long. That brought it out." Patient stated that on the same evening he had felt much better and later he had played cards and enjoyed it for the first time since the onset of his illness. He was discharged as recovered, but was asked to report a month later. At that time he telephoned in a booming cheerful voice, telling how wonderful he felt and expressed his gratitude. His symptoms did not recur during the subsequent year.

A successful abreaction can be aided by the use of benzedrine, dexedrine, or pervitin, either by mouth or intravenously. These drugs appear to be more effective in the civilian setting than the barbiturates.

The principle of emotional abreaction has also been successfully, although probably unconsciously, used by various cults and sects. Mr. Bunn's snake cult in North Carolina is a recent striking example, the touching of the snake during the ritual producing intense emotional excitement associated with abreaction (Sargant (4)).

I feel that the physiological result of abreaction as a form of excitation can be best understood in Pavlovian terms. It is conceivable that the intense excitation of neurons associated with electric shock may be the extreme physical variant of the same principle. It appears that the bringing about of excitation, quite apart from the interpretation and working out of the emotional material, has in itself a wholesome effect, irrespective of whether the excitation was produced by the reliving of a recent crushing-threatening episode such as combat stress, by the bringing out of old resentments by verbalization, by reliving of sexual conflict, by the participation in exciting ritual, or by the touching off of extreme excitation of the entire nervous system by an electric stimulus.

It must not be forgotten, however, that in spite of the strong physiologic components of the experience, the reliving and working out and the psychotherapeutic guidance and other forms of psychotherapy and understanding are of the greatest importance. In spite of all the lip service given to the unity of mind and body, many physicians still find it difficult to accept the fact that there is no separation of the psychological and the physical aspects of treatment; both should be utilized to the fullest.

We come now to the more specifically psychotherapeutic techniques, namely those techniques which promote insight and which have to do with interpretation either directly or indirectly. The indirect method is preferable, particularly for the beginner and in the beginning of a psychotherapy. It is very important not to overwhelm the patient with interpretation and thereby build up his defenses and resistances; it is important to feel out the patient before attempting to do so. It must be remembered that the scaling of strong defenses is a risky task, in psychotherapy as well as in war. The wise general or the wise psychotherapist will prefer a flanking movement; in the long run it will save time and risk.

4. *Shift of Emphasis.*—The "flanking movement" which should precede direct interpretation and frequently is sufficient to take the place of direct interpretation is the shift of emphasis. By this I mean the subtle shifting of emphasis from the complaint or the apparent conflict to the more important material that the patient may have presented quite inadvertently without having been consciously aware of its import in regard to his complaint. The advantage of this technique is that it does not arouse antagonism and resistance. It is wise to take as a starting point something that the patient himself told you. A recent example:

A 50-year-old man came to the outpatient clinic with a complaint of severe pain throughout the left side of the chest, for which he had first consulted the heart clinic, which referred him for neuropsychiatric consultation for the differential diagnosis of intercostal neuralgia or psychoneurosis. As frequently happens, the patient gave his problem away with his first sentence: "I want to explain to you why I come to this outpatient clinic instead of consulting a private doctor. I am a pharmacist, but I can't work in my line here in Massachusetts because my degree is not recognized here; but my wife wants us to live here because of our son. Therefore I have to work as a storeroom clerk and can hardly make enough money to get by." The patient then described with great vividness the pains in his left chest. He felt deeply distressed and alarmed about them, and they were a very profound reality to him. Careful examination in addition to the clinical and laboratory tests done before convinced me that this patient was not suffering from any organic disease. Furthermore, his marked state of anxiety and depression was positive evidence of an emotionally determined illness. On the other hand I felt that the patient would not take well to direct interpretation. At the conclusion of the examination which I had carried out with great thoroughness, I imperceptibly shifted from the discussion of his complaints to that of his life situation. Very soon the patient was well in the process of discussing his impasse and obviously eager for what suggestions would be made. I dropped the hint that many illnesses improve provided the patient is happy or finds a way of being happy. Before long we were discussing ways of improving his life situation. It turned out that a compromise was feasible. A neighboring state was chosen where he could work in his own field, yet be sufficiently near his son to suit his wife. The mere possibility of doing something about his problem and the support implied in the assumption that he had a right to consider his own occupational happiness relieved him. In the course of readjustment of his life situation the pain vanished and the danger of antagonizing the patient by the direct proffering of insight was avoided.

I recall a very similar experience from my wartime practice. An air gunner who had taken part in 5 rather harrowing combat missions was brought to the hospital with an obviously self-inflicted gunshot wound in his left foot. His incomplete recollection for his last 2 missions indicated considerable neurotic repression of stress. After his last mission the crew was off flying for about a week without being sent to a rest home, which is the setting in which self-inflicted injuries most frequently occurred. At the end of that week he had what he called the accident. The patient presented an outwardly calm appearance and a casual air, speaking with a good deal of detachment about his accident, minimizing the event and emphasizing that the injury was minor and that he was eager and ready to go back to duty. I felt that if I had given this man direct insight, it would have injured his ego and self-respect more than it would have helped him. Therefore I de-emphasized the accident, shifting emphasis from the dread issue of whether it would be accepted as an accident or not. I felt I had to be truthful and yet support and reaffirm his ego. I said, "It is not so important exactly how this happened; such a thing is always an accident, irrespective of how you take it." Thus de-emphasizing the word "accident" and including in it by implication acts of impulse which are not definitely and clearly premeditated, I convinced him that, although I had sensed the truth, yet I did not regard it as anything that interfered with his standing and honor, thus reaffirming and supporting his ego. I recommended that the wound be recorded as an accident and that the patient return to flying duty as soon as the wound was healed. He returned to full flying duty and completed 35 missions without recurrence of further medical or administrative disability. The therapy had consisted merely in an ego-supporting attitude in which emphasis was shifted from the past to the future.

The technique of shifting of emphasis rather than overwhelming the patient with direct

interpretation is of general importance. It is frequently particularly useful in marital problems.

In a recent case of this type a husband complained bitterly of the fact that his wife had unjustly suspected him of infidelity. In an ensuing conversation emphasis was gently shifted to the patient's own ambivalence, no doubt aroused by his wife's ambivalence and rejecting attitudes. When the patient asked, "Why do I resent that accusation so much?" he was asked in turn what he would like to do if he were not the nice conscientious person that he is. The patient then brought out the fact that many times he felt like leaving his wife or cheating on her. He said, "Yes, I had the idea of stepping out all right sometimes, but I know the difference between right and wrong enough not to do it. My conscience drives me and keeps me in line all the time; therefore I want a little appreciation." This was used as the opening wedge toward resolving his hostility against his wife and toward understanding each other's emotional needs better. In other words, his resentment and hostility against his wife were accepted as a legitimate grievance and thus the guilt feelings about his repressed wishes were relieved. In response to his own less ambivalent attitude his feeling of emotional security in regard to his wife improved.

5. *Interpretation.*—Although I refer here to interpretation of emotional illness, I believe it holds true also for physical illness, that interpretation of the illness to the patient is an important part of treatment. Interpretation is the most difficult part of psychotherapy, and it requires the greatest amount of skill, tact, and timing. It should not be attempted until one is very sure of one's ground and after one has established a good relationship with the patient. The results are seldom as dramatic as portrayed in the motion pictures. It is rather a slow process of understanding and results from a continued cooperative effort of doctor and patient. Nevertheless there are occasional instances where a dramatic denouement may be achieved by a well-timed interpretation for which the patient is ready. The most important thing is to interpret in terms acceptable to the patient and a genuine understanding of the patient is a prerequisite.

One of the few such instances of rapid recovery from a seemingly serious emotional illness was that of a young woman aged 29 years, who had married a widower with 3 children shortly before his going overseas during the war. All through the war she had looked forward to her husband's return from active service with keenest anticipation. Upon his return and after a visit to her husband's parents' home, where she first met the children of his first marriage, she lapsed into what appeared to be a reactive depression in which obsessive fears that she might do some harm to her husband's children made her particularly wretched. Thorough exploration including a 3-cornered discussion with her and her husband brought out the fact that this was elicited by the husband's cautious attitude in regard to additional children of their own, which hurt patient deeply because she felt herself and her marriage relegated to a place of second importance in her husband's plans and interests. When this interpretation was offered, it produced an immediate favorable abreaction. For the first time during the interview her face lit up and she agreed that this was it. In the same 3-cornered discussion this insight was then used psychotherapeutically in helping her husband to achieve a shift of emphasis in his own attitude. It was pointed out that while caution may be wise it could be emotionally stifling, and that optimism and looking forward to economic success without excessive delay in making his marriage a real one in the biologic and full sociologic sense should be the keynote. This formulation appeared to be accepted by him likewise with a sense of relief. The results were as durable as they had been dramatic. The patient has remained well and happy for a period which now approaches 3 years, and she and her husband have successfully started a family of their own.

Similarly dramatic results can sometimes be obtained by successful interpretation of anxiety and self-consciousness in terms of repressed aggressive wishes. However, such interpretations should be made only with the greatest of care and require a good deal of technical experience.

In this connection it is important to realize that in certain phases of interpretive or insight treatment the patient is not supported or built up, but on the contrary lowered or reduced, because he is losing his last-ditch defense against finding out things about himself which are socially unacceptable and deeply disturbing. Nevertheless it is important especially, for instance, in certain obsessive anxiety states, to bring about degrees of insight in which such losing battles and resulting realizations are unavoidable. Experience is needed in carrying through these phases of treatment, and supportive phases have to be interpolated in order to make the treatment program a constructive and helpful one. If this treatment pattern is viewed in Pavlovian terms, one cannot help feeling that it may be the sort of thing which Pavlov found necessary in states of

excitation in what he calls animals with "strong but unbalanced nervous systems." These animals have to be first reduced, in other words broken, and then built up. Here again is a certain parallelism with age-old ritual practices. From a Pavlovian point of view, it may be the same whether one "reduces" a person by making him conscious of his sinfulness, such as in the preliminary phases of religious conversion, or conscious of his infantile irrational strivings, such as in insight psychotherapy, or whether one disorganizes him temporarily by deep sedation with barbiturates; and whether one then builds him up by either giving him a feeling of redemption and grace by religious acceptance, or by giving him a feeling of having achieved maturity and insight by psychotherapy, or by allowing him to wake up from prolonged narcosis. In all these ways first an unsatisfactory behavior pattern is disrupted, disorganized, and broken, and then a new and better pattern is aided and built up.

Even in insight-promoting treatment, actions and attitudes are an important instrument of therapy. The actions and attitudes which have been found beneficial on the basis of psychodynamic understanding are remarkably similar, even identical, with those derived from true religious attitudes. F. Alexander and M. T. French(5) pointed out that the priest in Victor Hugo's novel "Les Miserables," written as long ago as 1862, who reformed the hero of the story, Jean Valjean, who had tried to rob him, by attitudes and acts of unexpected kindness performed a masterpiece of brief psychotherapy. It is of fundamental importance that age-old spiritual insight and modern psychodynamic insight have led to the same conclusion: that certain thieves are deprived people who must first be given to before they can be reformed. It is likewise of interest that modern psychotherapy has rediscovered the importance of love in the spiritual sense of the word as a therapeutic force.

Like all therapy which offers or suggests insight, even actions and attitudes if they serve that end are resisted by defenses to which the patient will cling until he becomes free enough to give them up. Thus Jean Valjean's first reaction to the priest's kindness was one of a temporary recrudescence of his hostile behavior before he became able to give it up altogether. Alexander and French point out that even in this respect Valjean's reform conformed to the familiar rebounding pattern of response of a symptom or neurotic attitude to psychotherapy. This pattern also conforms to Pavlov's laws of the higher nervous activity of the cortex: in Pavlovian terms this initial negative reaction could be described as negative induction by a new conditioned stimulus followed by positive induction which reinforces the stimulus sufficiently to allow it to irradiate. It appears that psychotherapy is a real force which conforms to spiritual as well as to natural laws.

6. A word about *suggestion* and *persuasion*. Suggestion is far less powerful than commonly assumed, especially in the most severe neurotic illnesses. Its success is practically limited to the field of hysteria and as an adjunct to the supportive treatment of psychotic conditions after and during the course of shock treatment, which greatly enhances suggestibility. Suggestion should be used with greatest care and only after the physician is sure that he can produce the suggested effect. In general practice this is pretty much limited to its use in hysterical states, providing the setting has been prepared and the essential conflict worked out prior to the actual giving of the suggestion. It is very important that the physician giving the suggestion be convinced of its effectiveness and does not allow himself to appear discouraged if the suggestion does not take effect immediately. I have found in hysterical states that suggestion sometimes does not reach its full effect until 24 hours later, even after the use of hypnosis. An important fact is first to be sure that the need for the symptom has been abolished or diminished by other psychotherapeutic techniques. Then the suggestion is frequently highly effective as the crowning conclusion of the treatment, but the stage must be set for it and the patient prepared for it.

It is important that the suggestion be couched in positive rather than negative language. It is as impossible to obey the command "don't worry," as it is to obey

the command not to think about a black and white speckled bear upon being told not to do so. The positive suggestions, "Be confident and optimistic" and "You will be happy, well, and strong," carry weight in the right direction. The same applies to the formulation of posthypnotic suggestions. The formulation, "You will have no headaches," is far less effective than the formulation, "Your head will feel clear and well." Apparently in suggestion we make use of receptiveness to categories of thought in which the relatively colorless prefixes such as "not" or "don't" carry relatively little weight. According to the experience of a shipping company incidental to fires aboard ships it was found that the inscription, "In case of fire do not open this door," carried far less weight than the subsequent version, "In case of fire keep this door shut." Salesmen know that the slogan, "Our radiators do not leak," no matter how truthful the statement, would not sell many radiators; psychologically the idea of their leaking carries more weight than the colorless prefix "not."

No matter how expertly administered, the power of suggestion should not be used indiscriminately. If a patient of limited intelligence and enhanced suggestibility is overwhelmed by suggestion without attention to the basic problem, the underlying personality disturbance can sometimes be aggravated by the precipitous taking away of the defensive symptom. We must always find out which function the symptom serves. This function is sometimes a very direct one, sometimes a symbolic one. The symbolism is sometimes very translucent, particularly in children, whose defenses are lower than those of adults. Suggesting a symptom away by frightening or bossing the child into giving up his symptom is not a constructive way to solve the problem. The symptom itself may be merely a defense. It is therefore very important to be sure to understand the symbolic meaning of the symptom before dealing with it in any direct manner. This applies also to other behavior difficulties, particularly in children, in whom the true meaning of the symptom is not difficult to recognize.

The child, for instance, who repeatedly sets fire to the family home more often than not comes from a home whose hateful atmosphere including a state of war between father and mother will make arson seem a radical and drastic remedy, to be sure, but not necessarily an illogical one. After listening to such a child, I try to improve the relationship between the parents. When the happiness of the home has been restored, the child will give up his obvious protest reaction. Any attempt to deal with the protest alone without understanding its meaning would have failed.

Stealing as a substitute for affection rightfully expected by the child but not forthcoming is well understood. Dealing with such a problem on a directly disciplinary level would merely drive the child into deeper and more radical rebellion. When the child sees that he is really loved, this unhappy substitute for love no longer interests him.

In psychosomatic illnesses it is likewise important to get at the underlying conflict rather than applying merely palliative treatment.

7. *Reassurance.*—As discussed before, reassurance like suggestion has to be given with great caution. It is essential for reassurance that the patient must believe that the doctor is truthful and that he has been sufficiently thorough to know whereof he speaks. In actual mental illnesses or severe neuroses reassurance is of only secondary importance apart from its use as an adjunct to general supportive technique. Reassurance, however, is of great importance as a preventive measure. Irrespective of whether or not a physician chooses to treat overt neuropsychiatric conditions in his practice, there is one field where he must do psychotherapy: that is whenever he deals with chronic or incurable physical illnesses. In these conditions a great deal depends on the doctor's psychotherapeutic handling of the problem. The existence of such an illness constitutes severe neurosis-producing stress, and it is frequently this superimposed neurosis or depression which may make the difference between an invalid and a reasonably active and well-adjusted individual. The way in which the physician handles such a problem may either prevent, control, or, on the other hand, sometimes even precipitate this super-

imposed neurosis. Thorough, warm understanding of the patient with a knowledge of his emotional needs will do a great deal to prevent superimposed neurosis in such cases. The problem begins with the way in which the diagnosis should be told to the patient. I personally favor giving the patient the true diagnosis, but in encouraging terms. Not telling the diagnosis sometimes makes the patients fear a worse possibility than even that which has been well-meaningly withheld. Another important point is to maintain in the patient a feeling of control, a feeling that he can do something for himself. Abandonment to Fate constitutes extreme stress which few people, except the most sturdy combat personnel in war, can take. Even there we found that flying stress and resulting neurosis, for instance, were markedly less frequent in fighter pilots than in bomber pilots, because the fighter pilot could maneuver freely on his own decision, while the course of the bomber pilot was fixed from the initial point to the target, irrespective of opposition encountered, the bomber pilot being able to take no maneuvering action of his own on this crucial, important part of the course.

One should therefore never tell the patient, "There is nothing I can do for you," without at least offering a program of things which he could do for himself, and to continue showing a helpful interest. All too frequently such patients are abandoned to their own devices. The rationalization for doing so is usually a perfectly ethical one. The real motive, however, is more complicated. The chronically or incurably ill patient represents a tremendous challenge to the physician's self-esteem of his own healing abilities, which will frequently put him on the defensive, especially when the patient on his part enhances this challenge by openly hostile, demanding, or critical attitudes. It is therefore understandable that in such a setting the doctor, especially when he is sensitive to criticism and hostility, may tell the patient that he can do nothing for him in such a way as to imply, "There is nothing anybody can do for you," which to the patient means complete rejection and abandonment. We must never forget that a principal function of the physician is to give hope to the patient and to relieve his relatives of responsibility by not dodging any responsibility himself.

It is also important to guard against an attitude of rejection in referring mental patients to a psychiatrist. The manner of the referral frequently determines success or failure of the patient's first contact with the psychiatrist and conditions his readiness to accept treatment. If the physician refers the patient with an attitude of rejection and detached disinterestedness in his problem, which to the patient implies, "You are crazy; you ought to go to a psychiatrist," he will come to the psychiatrist with a chip on his shoulder and cooperation will be difficult to obtain. If, however, the physician refers the patient to the psychiatrist in the same manner as to any other specialist, saying, for instance, "I want you to see my friend Dr. So-and-so; he is a specialist in this field, I am sure he will help you and I shall keep in close touch with him," the patient and his relatives will come prepared to have confidence, and cooperation will result as a matter of course.

Conclusion.—I should like to conclude with a few do's and don'ts in the use of psychotherapy in office practice. In general you can't go wrong with a warm, supporting attitude, and in offering the patient opportunity for ventilation. If this ventilation should be associated with a marked emotional abreaction, be sure that you can maintain your objective supporting attitude in the face of this abreaction, even if it should include the expression of hostility toward you. Do not interpret unless you are really sure of your ground—much damage can be done by novices.

If the patient improves only at the price of too much dependence on you, or if he should become dependent on you without improving, refer him to a person with more skill and experience in the field of psychiatry. Remember that dependence is regression into an infantile state. While such regression may sometimes be necessary as a transitory phase during treatment, and frequently is undesirable even then, you must ultimately wean your patient and help him to mature. A physician of my acquaintance who rather prides himself on his self-taught skill in his

psychotherapeutic management of neurotic patients told me once as a proof of his accomplishments that his cured neurotic patients retained so much confidence in him that for years after treatment they would make no major decision without asking his advice, even in entirely nonmedical matters. To me this sounded as if a surgeon were taking pride in the fact that his patients were letting him dress their still-draining incisions for years after each operation. We must keep our goal firmly in mind, which is to help our patients to achieve health, happiness, maturity, and independence. In every psychotherapy there comes the time when we must throw the ball of responsibility determinedly to our patient, and trust him to carry it.

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THE PSYCHIATRIST AS MARRIAGE COUNSELOR [1]

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Marriage counseling is a form of short-term psychotherapy dealing with interpersonal relationships, in which problems relating to marriage are the central factor. The field is subdivided into premarital and postmarital counseling. It is an approach carried out essentially at a conscious level. The interview is conducted on a discussion basis in which the therapist actively participates. If, as therapy progresses, unconscious factors are discovered that necessitate long and involved psychotherapeutic techniques, the case ceases to be in the field of marriage counseling. It becomes a problem in clinical psychiatry. Obviously the therapist is not in a position to make this distinction until he has come to know his patient. Sometimes a relatively simple presenting problem will develop unforeseen complexities, while an apparently complex marital situation may yield to a simple short-term approach. In making the above distinction between marriage counseling and clinical psychiatry, therefore, the differentiation is based primarily upon the degree of complexity of the presenting problem and accordingly the types of therapeutic techniques necessary to meet it.

Over the past 50 years, concepts of the proper field of clinical psychiatry have been extended far beyond its original focus on the treatment of the psychotic. Psychiatry is now concerned with all types of emotional problems as well. Properly, then, all marriage counseling falls within the domain of psychiatry. Yet, just as simple mathematical problems may be solved without calling the aid of a mathematician, so it is useful to define a field where properly trained and personally qualified individuals with professional backgrounds other than psychiatry, as well as psychiatrists themselves, may render useful service.

A distinction must be made between marriage counseling and the types of family counseling carried on by many social agencies. In the latter, many aspects of marriage such as parent-child relationships, vocational adjustments, housing, budgeting, etc., are dealt with, but only rarely are the psychosexual components of marriage considered in any detail. It is these psychosexual components that constitute the major emphasis in marriage counseling. Help on other aspects of marriage may be obtained from a wide number of channels—social and government agencies, vocational advisers, child guidance clinics, economic specialists, etc., as well as a vast array of technical literature, but there is a very real dearth of assistance available in the psychosexual field. The hush-hush attitudes toward sex, which are still so widely prevalent in our culture, limit competent counseling in this area to a relatively small, highly trained group who are able to talk about sex with ease and candor and with a scientific objectivity tempered with warmth and understanding. The marriage counselor has no platform of his own toward which he tries to lead his patients. He sees their problems in the light of their own cultural backgrounds and previous conditionings. He maintains a nonmoralistic attitude toward individual variations in sexual patterns. His rôle is to help his patients work out solutions particularly geared to their own needs and circumstances. It is recognized, of course, that sex constitutes but one form of expression of an individual's personality and that personality as a whole is involved in marriage. The marriage counselor must, of course, be competent to deal with all kinds of problems involving personality adjustments. But it is in the sexual aspects that the average individual has received the least education and the least emotional orientation. Marriage counseling hence often focuses upon these.

Because of the relatively simple techniques involved, properly trained and personally qualified individuals in fields other than medicine may function as marriage counselors. Included in the active membership of the American Association of Marriage

[1] Read in the Section on Private Practice at the 105th annual meeting of The American Psychiatric Association, Montreal, Quebec, May 23-27, 1949.

Counselors are individuals with professional backgrounds in psychology, sociology, social work, theology, and education, as well as doctors specializing in internal medicine, urology, gynecology and obstetrics, and psychiatry. As the numbers of properly qualified nonpsychiatric counselors increase, their work can become an adjunct service lessening the heavy load that psychiatry is currently carrying.

It must be remembered that many people with problems relating to marriage prefer to go to a nonpsychiatric source of help. Our specialty has not as yet succeeded in shaking off all of the popular opprobrium connected with it, and our colleagues in other fields may thus be able to reach many who would hesitate to come to us. Spurgeon English(1) has said: "I do not see why anyone within psychiatry should feel concerned about marriage counseling encroaching on their province for several reasons, one being that there are so many serious problems in the realm of psychosis, neurosis, psychosomatic conditions, and character disturbances, that we already have every psychiatrist working overtime these days."

During the past year a joint committee representing the American Association of Marriage Counselors and the National Council on Family Relations has worked out minimum standards of qualifications for the marriage counselors of the future. These include definitive statements as to educational background, clinical experience, and personal qualifications. These two organizations are currently engaged in setting up a board of certification for qualified marriage counselors. It is further proposed to draw up standards for the organization and operation of marriage counseling clinics or facilities. These steps are all aimed at combating the present chaotic state in the general field of counseling, where anyone with or without training and with or without a license may set himself up as a "counselor" and, for a fee, may deal with the most intimate of personal problems. Many of us in our clinical practice have encountered individuals who have passed through the hands of commercially-minded impostors with no professional training and have seen what major harm and human misery they can produce. They are a motley crew—marriage brokers, astrologists, graphologists, palmists, spiritualists, numerologists, and even beauticians who claim they can "cure" inferiority complexes. The most effective means of combating this situation is through the certification of qualified personnel and the education of the public to accept help only from individuals of such caliber. The advantages of such certification have already been demonstrated by the American boards of medical specialists.

The psychiatrist as marriage counselor is in a unique position for service in this field. His specialized training enables him to deal with complex emotional problems that may be inherent in seemingly simple situations and to recognize them more quickly. If such complications are found, he can thus carry his patient through, rather than having to refer the case elsewhere, as is necessary for marriage counselors with other professional backgrounds. It is always disturbing to a patient to change therapists in midstream. With a psychiatrist in charge, the case may be carried forward uninterruptedly with the full armamentarium of psychotherapeutic approaches available as needed. To the psychiatrist, therefore, the question as to whether a given case falls within the field of marriage counseling or carries over into clinical psychiatry is largely an academic one.

It is important to realize that the training that most of us in psychiatry have had does not fully prepare us for work in marriage counseling. We have been taught to understand the workings of the human mind and the influence of the mind upon behavior patterns, particularly in the psychosexual field. To be of full potential service in marriage counseling, we need added training and background in the fields of gynecology, urology, sociology, and anthropology. And to be at our best as marriage counselors we need to have a real interest in the field. For, in this subdivision within a specialty, there are undoubtedly many whose interest centers in the treatment of the psychotic rather than in working with essentially normal people. It is noteworthy that the Veterans Administration is incorporating clinical instruction in the techniques of marriage counseling in its neuropsychiatric resident training program. Such instruction in medical schools as part

of a fourth year program under departments of psychiatry would be a valuable addition to present-day curricula.

As psychiatrists engaged in private practice, we are accustomed to seeing patients whose presenting difficulties—psychoneurotic or otherwise—are of sufficient degree to interfere perceptibly with their everyday lives. Those seeking advice in the marriage counseling field generally give no surface indication of such difficulty. An analysis of 200 consecutive cases seeking premarital advice at Marriage Council of Philadelphia(2) indicates that 75% fall into the so-called "normal" group. Of these about one-quarter sought advice primarily regarding contraception. The others were eager for this information but were "equally anxious for other facts and for reassurance that would allay their uncertainties as they faced marriage." Until one has worked clinically with this "normal" group, one will be amazed (or perhaps frankly skeptical) at the far-reaching therapeutic impact of a few sessions of counseling carried out wholly at a conscious level.

Take, for example, the case of the girl of 21 who presented herself to the counselor in a marked state of tearful agitation. She felt that she must break her engagement. She loved her fiancé deeply, but she felt that she would wrong him by marrying him. There was something in her past life which she had been trying to shut out of her mind, but now, as marriage approached, this "thing" was haunting her more and more and branding her as "unfit" for marriage. This "thing" proved to be the usual sort of history of masturbation in a girl brought up in a hidebound environment where all sex was anathema. Two hours of counseling melted away this patient's guilt and provided her with a correct concept of the normality of such a history of masturbation. Other guilt feelings in regard to minor physical intimacies with boys were also ventilated. The patient was found to be completely ignorant in regard to sexual anatomy and physiology, and, through the excellent drawings in Dickinson's "Human Sex Anatomy"(3) and by his three-dimensional models of the pelvis(4), she was given a working orientation in this field. She was referred to a gynecological colleague for pelvic examination (which was normal) and for instruction in self-dilatation of the hymen (which allowed her to be fitted contraceptively before marriage). The fiancé was also interviewed. The patient's difficulties were interpreted to him and his cooperative understanding was secured. In the final interview both were seen together and an easy, candid discussion of the psychosexual aspects of marriage took place. The total time of counseling was 4 hours. Two months later they were married and the marriage has proved to be a successful one.

To some individuals without clinical experience in marriage counseling, this abbreviated case history may call forth either of two reactions. First, the presenting problem might seem so simple and elementary that anyone could handle it. The problem is simple, to be sure, but unless handled with a sensitive skill born of experience, this rapid result could not have been obtained. Or secondly, those psychiatrists accustomed to deep-level therapy with patients having complex emotional difficulties might question whether such guilt feelings as this patient had could so readily be dispelled. Would they only seemingly evaporate and might they not return to disturb her later on? Those of us who have worked with patients of this type—patients of essentially stable emotional make-up but who have been the victims of faulty sex education—contend that such results are permanent. Premarital interviews are thus an important and rewarding aspect of preventive medicine.

Premarital counseling is, of course, closely allied to the field of education. It is largely informative in its scope. There is an insistent demand on the part of high school and college students of today for factual, realistic courses in human relations. Educators are doing their best to meet this and are edging forward despite the opposition sometimes provided by religious bodies or by ultraconservative boards of trustees. It is heartening to realize that, at the present time, courses in marriage and family relations are being given at an undergraduate level in 596 colleges(5) throughout the United States, mostly by colleagues in other professional fields. Such courses are of very real value. However, they are only a partial substitute for premarital counseling. In the classroom there are opportunities for the presentation of factual material and for class discussion of various points of view regarding the psychosexual and other aspects of marriage. The lecturer has no opportunity, however, of working with the individual attitudes of the individual student. In some institutions this discrepancy is recognized and individual counseling facilities are offered as an adjunct to the marriage course.

The mental hygiene of marriage must concern itself primarily with individual attitudes, in that the patient's factual knowledge is of little avail if attitudes of shame and resistance regarding sex continue to exist. This emphasis on attitudes constitutes one of the most important aspects of marriage counseling.

Public interest has been aroused in a more adequate program of preparation for marriage by many popular articles attempting to analyze the causes behind the current high divorce rate. A recent medical editorial by Walter Stokes(6) states:

> It is significant that all the great religious groups in the United States—Protestant, Catholic and Jewish—are now officially and actively concerned with the realistic preparation of their younger generation for marriage and that they accept medical service as part of such preparation. Several years ago the Federal Council of Churches of Christ in America (Protestant) established a Commission on Marriage and the Home. This commission has approved premarital medical service as part of its recommended preparation of young people for marriage. The National Catholic Welfare Conference maintains a Family Life Bureau which endorses premarital service to those of the Catholic religion. The Jewish faith supports premarital service through its Institute on Marriage and the Family. . . . . There are still some religious doctrinal restrictions about the scope of premarital medical service, but the restrictions have been remarkably liberalized within the past two decades.

We in psychiatry can do much to promote further liberalization of such doctrinal restrictions if we will work cooperatively and understandingly with these religious groups. There is an unwarranted concept in the minds of many lay people that psychiatry and religion are by their very natures in opposition to one another. This, of course, is not the case. Yet there has tended in the past to be too sharp a cleavage between the two groups. Within the past several years there have been a number of fruitful conferences between psychiatrists and members of the clergy where points of view relating to premarital and postmarital problems have been aired and shared, with a resultant broadening of common point of view and understanding. There are real potentialities in the future for psychiatry and religion to draw closer together, each contributing to and, in certain respects, modifying the point of view of the other, with resultant benefit to the field of marriage counseling.

Any detailed discussion of the various types of psychosexual problems encountered in postmarital counseling is unnecessary here. For the symptoms of frigidity, dyspareunia, vaginismus, impotence, precocious ejaculation, etc., are frequently encountered in the private practice of psychiatry. There are, however, certain generalities germane to this whole group of conditions that are important to mention. First of all, there is a widespread misconception among the laity that marital maladjustments are primarily due to faulty techniques of sexual approach on the part of one or both partners, and that hence the learning of new skills will, in itself, resolve the marital difficulties. In my own clinical experience such simple and largely mechanical solutions are quite rare. One much more commonly encounters situations in which the couple's basic attitudes toward sex and toward each other constitute the primary difficulty. Instructing such a couple in the refinements of a new sexual approach is fruitless. One must painstakingly get down to the roots of these emotional attitudes and remove them before any real attempt at sexual readjustment is possible. Conversely, if attitudes toward sex and toward each other are healthy, it is remarkable how much bungling and clumsiness in sexual relations approach there may be without its constituting a real hazard to marital happiness.

To illustrate the distinction between an approach to techniques and to basic attitudes, the following two cases may be briefly cited:

> A couple, married 6 years, stated that they had never been happy in their sexual adjustment. The wife had always failed to reach orgasm and following intercourse was left in a tense, irritable state. The husband was satisfied physically, but was deeply concerned because of his wife's sexual unhappiness. It was found that the husband had had no premarital sexual experience and that, even after 6 years of married life, he was unaware of the difference in rate of responsiveness existing between man and woman. In their intimacies, foreplay had been almost completely absent. Here an informative discussion with each partner readily resolved the problem. This was possible, however, only because both individuals were essentially nonneurotic in their make-up, and even with this long-standing difficulty their basic love for each other had not been affected.

In contrast, let us consider another marriage of 6 years' duration where again the husband displayed the same lack of understanding in his sexual approach, and the wife displayed the same type of distress following intercourse. In studying the wife, however, it soon became apparent that even had the husband been an accomplished lover her difficulties would have remained. For the patient had experienced a minor sexual incident in childhood about which her mother had reacted so violently that the patient had carried with her throughout her life a marked sense of inferiority and an unconscious conflict in regard to all sexual activity. Here, obviously, long-term, deep-level psychotherapy was necessary before she could be expected—even under optimum circumstances—to respond normally.

The longer marital difficulties have existed before help has been sought, the greater, as a rule, the therapeutic problem. It is obvious, then, in making a distinction between the field of marriage counseling and clinical psychiatry, that the nonpsychiatric marriage counselor may function more frequently in premarital problems and in problems arising shortly after marriage than in those of long standing. The latter are more commonly problems of clinical psychiatry, for here a short-term, conscious-level approach is usually ineffective.

The marriage counselor's effort is directed toward making marriages really work. But at times irreversible changes have set in. To try to hold a marriage together that is bursting apart at every seam is the act of a zealot, not of a scientist. The marriage counselor can, however, do much to ease the impact of divorce upon the couple concerned. He can help them to face the fact that their marriage has failed beyond hope of repair and that it must be terminated in as fair and as mutually considerate a manner as possible. The rancors, the tensions, the accusations and counteraccusations that are so commonly encountered in divorce actions can largely be avoided. The counselor directs his efforts toward helping the couple to understand the causes of their failure, to mature by passing through this experience, and so to become potentially better candidates for some possible marriage in the future.

Newer concepts of psychiatry place upon the clinical psychiatrist a responsibility larger than that of a doctor-patient relationship. The psychiatrist must look beyond his patient and his patient's presenting problem to the society of which his patient is a part. Through his patient the psychiatrist can extend his influence to others. He can teach parents and potential parents to become better qualified as parents, particularly in their ability to make instruction in matters pertaining to sex a natural and integral part of their children's education. Dynamic psychiatry has as its basic tenet the harmful effect of early distorted psychosexual conditioning. If the generations of the future are to become progressively less neurotic, each succeeding generation must be helped to get off to a better start. We as psychiatrists can play a major rôle in this effort. Our impact upon an individual during the psychiatric interview can be far greater than any influence that mass media, such as literature, lectures, radio, etc., can have upon him. For here instruction can be geared to the patient's own state of development as of the moment, and the particular situation existing between him and other members of his household can be dealt with individually. Day after day we see in our consultation rooms the varying degrees of wreckage caused by faulty upbringing. We should not be content with being mere repair men. We must be directly concerned with the building of better models in the future, and in taking an active rôle in their design.

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CASE HISTORY OF RUTH STEINHAGEN

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On June 14, 1949 the baseball world was startled by the announcement that a member of the Phillies in the National League had been shot in a hotel bedroom by an admirer. This happened at the Edgewater Beach Hotel in Chicago. The assailant, a 19-year-old baseball fan and admirer, gave herself up immediately to the police. When she appeared in Felony Court 2 days later, His Honor, Matthew D. Hartigan, at the request of States Attorney John S. Boyle ordered a psychiatric examination by the Behavior Clinic of the Criminal Court of Cook County. She was seen almost daily for a period of two weeks and a résumé of the information obtained follows.

The social history[3] was obtained from members of her family and from two of her close girl friends.

Both parents came from Berlin at the age of about 22. They were married in New York and lived in and around Chicago. Both had approximately a high school education. The father is a die setter. He is a good provider and has worked steadily. He is described as restless and apparently thinks and acts faster than the mother. The latter is described as a good housekeeper who preferred to work problems out with her children rather than tell them off as did her husband.

The patient, the older of two girls, was born in 1929, a year after her parent's marriage. Labor was prolonged but instruments were not used. She was toilet trained at 9 or 10 months, walked at 13 months, and began talking at 16 months. Her first hospitalization occurred at the age of 1 (acute tonsilitis). At the age of 2 she had whooping cough, which persisted for several months. At 3 she was hospitalized 4 weeks with scarlet fever. At the age of 4 she had chicken pox and at 5 measles. Following this she developed a bronchial cough, which was treated by X-ray therapy. At the age of 10 she and her 9-year-old sister were kept at home for a while with a cold and on returning to school her mother was informed that they again had scarlet fever. At this time she had her tonsils removed and the doctor said she was "jittery." "She had chewed her nails until it looked like she would eat her whole hand." Since, she has been "awfully nervous chewing her nails to the quick." About this time she told her mother that she had a "strange feeling as if her right eye were over the top of her head." Her periods started at 14 and were irregular until the age of 16. At this time she was taken for a physical examination and she refused to see a male physician. It was only with much persuasion that she permitted a woman physician to examine her. The physician noted that there was no breast development and that she was tall, thin, and awkward.

She entered public school at the age of 5, made excellent grades and at one time was given a double promotion, which according to her parents she has always resented as she preferred to remain with her own class. She graduated from the 8th grade at 13, had 2 years of high school, and 2 years in a commercial school graduating at 17. Her life's ambition was to become a private secretary.

She worked in factories during the vacation period. On completing her commercial course the school wished to place her but she wanted to secure her own job. After graduation, however, she changed in that she became fearful of her work, felt that she might fail, and became fearful of meeting people. At her first interview for employment she was given a questionnaire to fill out after which she was told that she was too nervous, that she needed a rest and should be under a physician's care. This did not deter her and she finally secured a position

[1] Director of the Behavior Clinic of the Criminal Court of Cook County, Chicago.

[2] Associate director of the Behavior Clinic.

[3] As obtained by Mrs. Emma Lou Arvidson, director of social service.

as a stenographer with another company. When the time came to take shorthand, she became panicky and was finally placed as a typist and billing clerk. She worked hard, assumed responsibility, and was well liked by her employers.

As a child she attended the Lutheran Church with her parents. Of late she has attended the church of her girl friends. With one she attended the Moody Bible Institute, where she would sit "staring and trembling during the services."

Her parents describe her as good looking. When first seen by the examiner she gives the impression of being very cheerful, kind, friendly, and cooperative. As a child she was gay and happy. Reaching adolescence she changed in many ways. She never wanted people to look at her. She could not endure men looking her up and down while standing in the street car. She worried because people were watching her. Sometimes she was very careful about the appearance of her clothes and nails but at the same time would pay no attention to her shoes. She would buy new clothes but preferred to wear old ones. She had several girl friends from grade school days and was easily influenced by them. She liked music and would go through periods when she would play nothing but records of Liszt, Andy Russell, or boogy woogy. She would play a record over and over to the great annoyance of the family. At 16 she attended a ball game with a girl friend and the girl friend's brother. She dated him at his insistence but was never really interested. At times she made a date with him and failed to show up. She told her parents his good night kisses didn't mean a thing to her. She is a very methodical and exact person about money matters repaying to a nickel any debts she may incur. When she became 18, she told her parents she could do as she pleased and refused to take suggestions from them.

After she became interested in ball games, she began to talk in a subtle manner about Eddie Waitkus, a Cub player, but her family paid no attention to her. She collected his pictures and any press notices she could find. Her friends likewise began to collect the press notices for her and it became more than a teen-age infatuation. It continued in the winter as well as in the summer. Her father, her employer, men on the street began to remind her of him. His number was 36 and she became sensitive to that number. She bought records that came out in 1936. Because he came from Boston she began to eat baked beans and ordered them constantly. At home she refused to talk about anything except Eddie. If her parents changed the subject she deliberately brought it back saying, "Let's talk about Eddie." She attended all the ball games in which he played and would wait with the bobby-soxers for the players to pass. She got as close to him as possible but would never say a word. She would get pale and tremble and once almost fainted as he went by.

At work she became nervous and miserable because she thought her employer looked like Eddie, and in November 1948 she suddenly walked away from her job in mid-afternoon. She roamed the streets until night looking for him. After this her parents made arrangements for a 6 weeks' leave of absence. Her father took her to a psychiatrist who saw her daily for a period of 10 days. According to the father he had her lie on a couch and listen to the doctor's voice from a wire recording machine. He also gave her literature of the morale-boosting kind containing many quotations such as, "I must get well." The doctor after the 10-day treatment left town and told the family she should see another psychiatrist. She consulted another once, but being fearful of going into crowds refused to see him again. She remained at home and rested until Christmas, at which time she returned to work in another department where the work was not so confining.

In January 1949, she was unhappy because the work in the office was speeded up. She wanted more rest at home and because she was listening constantly to Lithuanian programs she was granted permission to take a room away from home. At this time she was studying Lithuanian and reading all the books she could obtain on the subject. (Eddie was of Lithuanian ancestry.) Sometime earlier she had seen "The Snake Pit." She saw it again and again saying that one of the actors reminded her of Eddie. She felt that it was sure evidence that those

who are considered insane are the normal ones but their keepers are crazy. She returned home each night for her evening meal. She refused to allow any bugs that flew in the house at night to be killed. She caught them and would carry them outside to be released. On her return to her room she would spread all her pictures of Eddie on the bed and make a shrine of them. She carried his picture in her billfold and slept with it under her pillow at night. She spoke of suicide many times to her parents but they did not take it seriously. (There is a history of suicides by the maternal grandmother and a paternal aunt, in Germany after World War I.)

Additional information from her girl friend revealed that the first time Ruth noticed Eddie was on April 27, 1947 at a ball game when someone near them shouted, "Hello, funny face" at him. From that time he became her favorite player. She attended every game possible and was interested in no one but Eddie. Each time they attended a game they watched the players leave. Ruth enjoyed motion pictures relating to psychiatrists and prisons. If talking about movie actors the conversation always returned to Eddie. When asked if she wanted to marry him she replied she seemed to want to mother him. She wanted to be with his mind and with his intellect. Sexual matters were never discussed. When the informant suggested that she meet Eddie socially she replied that she couldn't stand it, that she "knew she would spill all over herself if she were face to face with him." Frequently she would say she could feel that he was near her. She always had his picture with her and frequently she would take it out and talk to it saying, "Oh you are so cute" or "You made such a good play today." She always said she was going to take him with her when she went for a walk. Informant confirmed her interest in the Lithuanian language, customs, etc. She was able to say, "I want to go to the hotel" in Lithuanian. She was always down in the dumps when the Cubs were out of town. When Eddie was traded to Philadelphia she promptly changed her allegiance to that team. She spoke frequently to her girl friend of suicide "because life was routine and she was tired of conventional people who did not understand her." The only complaint she made to her friend was that her family was too strict. Informant does not remember her ever showing affection for anybody. She was always quick, always on time, and was furious if kept waiting. Informant went with her to buy the gun and after purchasing it Ruth was as pleased with it as with a new toy, wanting to hold it. Both attended the game on June 14 but Ruth left early stating that she did not want to pass the wealthy women in the hotel lobby because they looked at her.

Ruth's sister revealed that when young they shared their toys. As they grew older and went to school, they were both unhappy. They did not like the neighborhood and their associates. The other children always made fun of them and they were unable to fight back. The sister felt that Ruth was always more independent and careful but was influenced by her companions. When she left her home she took a suitcase full of teddy bears, dolls, and toys that she had as a child. She spoke frequently of suicide to her sister and as she felt the sister was not sympathetic she quit confiding in her.

The psychological examination [4] performed in the Cook County Jail revealed an I. Q. of 99 on the Wechsler-Bellevue scale indicating normal intelligence. The verbal scale was 96 and the performance scale 102. She had brief attention span and it was necessary to call her back to the test items. The Rorschach summary: "We have here indications of a childlike emotional status, incapable of meeting personality conflicts. Her pseudo-solution has been to use reality selectively. It is felt that this investigation indicates an incipient schizophrenic psychosis." The Terman and Miles Attitude-Interest Test did not indicate any tendencies of homosexuality. She falls in the middle range for women. The inventory indicated a gross misemphasis of sympathies and a bizarre attitude toward society. She has great sympathy toward animals and insects but is indifferent toward small children and old people. She gives lip service to social conventions but actually

[4] Examined by Mr. Robert C. Nicolay, clinic psychologist.

her system of personal evaluations places these very low.

The physical examination revealed a tall, thin, 19-year-old white female who presented no gross pathology in the examination of the heart, lungs, and nervous system. She was 5 feet 11 inches tall, weighed 133 pounds, blood pressure 120/88, pulse 64.

The mental examination was performed in the Cook County Jail. She was seen and examined on several occasions. On each visit she was cooperative, at ease, and anxious to talk. Only twice was it noticed that she showed any emotion whatsoever—once after a pelvic examination and again when discussing the purchase of Eddie by Philadelphia. It was felt that she was not withholding information. She discussed her family freely.

My father is very nice and stubborn. I am stubborn too, that's the reason we don't get along. He said I'm disagreeable. I used to snap back at him. He said things about Eddie and I didn't like it. He didn't like me to wear lipstick. I didn't care what he thought. My mother was nice to me. She wasn't stubborn. She could see my side too. In the first 2 years of high school I liked the very popular music and he didn't like that either and used to tell me to shut it off. I used to get real mad and go in my room and beat my hands on the bed and then when I went crazy about Eddie we used to fight about that. He said girls nowadays must be crazy using lipstick, finger nail polish and going after ball players and dancing to jive music.

Church attendance was mentioned briefly:

I used to go to church on and off. At first the Lutheran church. Then I got interested in Youth for Christ, that's Moody. The regular church was the Presbyterian church. I went there for a year. I was baptized there. I went to a conference. I was supposed to come back and make a report. When I came back I was scared to go up in front of everybody so I didn't go back and have never returned. My mother thought it was good for me. My father is an atheist but he didn't care.

Of grammar school and high school she complained:

Some kids used to come and pick on me just because I was dumb at the time. Let them do anything they wanted to me. Once there was a girl living across the way, she took my doll clothes, anything that I had, and I never said anything about that. Anytime anything was said about boys, the girls used to say, "go on, you don't know anything about them." I was so gullible. At about 8 I used to imagine all sorts of monsters would come out of the dark, ghosts, dead people. I was afraid I would see one. Kept going about like that until I was in high school, then I just forgot about it. When I was little I used to lie in bed and have a terrible impulse to laugh and laugh and laugh.

Heterosexual and homosexual relations were denied.

My mother told me (about pregnancy) when I was 12 years of age. I never knew about the tactics they used in high school. They used to have symbols for such things. If a boy dropped money it was supposed to mean you would sleep with him. All kinds of dirty stuff. If he took your hand and held it a certain way it would mean, it meant that way too. That's why they looked down their noses at me because I didn't know those things.

Masturbation was indulged in about once in every two months starting at about 8.

I had a dream one night. All I could remember was a jar of cold cream. Not again until about 14. Just more or less in fits and spurts of 4 times in a 4-month period and then I would forget about it and then it would be like that again. I can't put it in words. Feels all relaxed. Like stretched out after being cramped up. Massage my body.

Her girl friend told her that even men could get together. "I don't know how, I just know it could be done." When questioned about homosexual relationships she replies,

It always disgusted me. I know about it but I couldn't see how it could be done, not when there wasn't a man around. We always discussed what baseball players did after hours, she only told me that once. We used to wonder about their personal life, what they were like off the field. We knew they weren't innocent, the life they lead. We heard about one who got his nose bit out by a blond in a cocktail lounge. We used to take walks in the Wilson-Sheridan neighborhood and from the ball park up north. We just liked the neighborhood, the ball player atmosphere. I don't like the idea of people coming near me [sexually].

Suicidal thoughts were frequently expressed:

I used to feel like committing suicide. I had more reason for it than against it. At 10 or 12 years of age I had a feeling of going crazy. A little later on I had a horrible desire to kill my mother. I loved her but I wanted to kill her. I had the thought of going into the kitchen and getting a knife but I never did.

In 1947 the first plans for suicide were strongly entrenched:

I was feeling pretty low at the time. I couldn't get the secretarial job I wanted. Then I was more

nervous than ever and felt I wasn't making anything of myself. I didn't actually try. I thought about a gun. The first thing I thought of was sleeping pills, then I found out they were hard to get. I was going to do it in any way not painful. A relative of mine, 'long time ago in Germany, jumped down a well and drowned herself. Also my aunt, father's sister. My mother told me once after a big fight. She told me she was going to commit suicide. If we hadn't come along she would have. I tried to kill myself that night but I lost courage. In June 1948 once I thought this way. Once I thought this way, I couldn't get it out of my mind altogether. The idea was to kill Waitkus and then kill myself. I just thought about it all the time until I did go out and kill him.

In discussing dreams she adds:

I had many dreams and they all came true. Plenty of dreams. Never dreamed of killing anyone except once. It was the idea of Waitkus. I had the idea of shooting him. I was sitting with him in my arms and I did after that. At times the dreams were of prisons.

Her previous psychiatric examinations were purposely not discussed. When questioned about psychiatric readings she replied:

I don't ever read the whole book. Books about paranoia, schizophrenia, and different kinds of complexes and why people get the way they are. I haven't classified myself but I'm not crazy. I don't believe in any of those classes. I read everything that interests me about personality. I read a book on—I think it was part of the American Penal or Prison System because I figured I was going to prison. I might find out what it was like.

In discussing her present difficulty in the first interview, she summarized:

It's a mixture of things. First of all I think I shot him because I liked him a great deal and I knew I never could have him and if I couldn't have him neither could anybody else. Secondly, I had the idea that if I shot him I would have to shoot myself. In the third place I wanted publicity and attention for once. I think that's about as close to the reason why I shot him. . . . . About the first year I was crazy about him. The second year you know when I was self-conscious I thought people were looking at me, and I always thought my head was shaking so one day I pretended he was with me and I talked to him, not out loud, it was in a mental sense, not physical, and we walked down the street together. Whenever I walked home from my mother's home, she used to say "Take the street car home." I said, I didn't want to because I had Eddie with me. I didn't tell her that. She would have laughed at me. I told my girl friend. I have never joked about it. I remember one day, that was the 27th—that is our anniversary—it came in a newspaper clipping and I had the pictures. That was the time I was reading it and saw his pictures. He was holding a gun. He as much as told me to go, right there on the picture. I told him you got me coming there on the 27th, what a nice anniversary present. After I saw this ball player on April 27, 1947, I used to go to all the ball games I could and just watch him, and we used to wait for them to come out of the club house after the game and all the time I was watching him I was forming the idea in my mind of killing him. As time went on I was getting nuttier and nuttier about the guy and I knew I couldn't get to know him in the normal way. And I kept thinking I would get him. I'll never get him and if I can't have him nobody can and then I decided I would kill him. I didn't know how or when. I decided to do something about it. Then I decided to kill him with a gun. It would be the easiest way. I actually got the gun in May. I didn't think I would have the courage to get a gun because I'm afraid of one. I knew I couldn't get a small hand gun like I wanted because you got to go through the trouble of getting a permit, so I went to a pawn shop and I got this second hand rifle. A girl friend was with me at the time we took it up to my house and hid it. After that I looked up on the schedule to see when the Philadelphia Phillies would be here. I put in my reservation for the time. During that time of waiting I learned how to put it together and take it apart. Then I waited until it was time to go. The whole thing seems so funny. We went over to my house and picked up the gun, I took a taxi back to the hotel. The next day I went to the ball game. I only stayed till the 7th inning and then I took a taxi back. Then I ordered a radio from room-service and some drinks, a daiquiri and two whiskey sours. Then I sent for the bell boy and gave him $5.00 and told him it was important to give him (Eddie) the note. The bell boy called that Waitkus wasn't there at the time but he put the note on the dresser so Waitkus could see it when he came in. I figured he was out for a good time and so wouldn't be back for a long time, and so I sat down and listened to the radio, that was about 6:30. At about 10:30, I listened to the radio and finished the drinks. I sat down and waited. I kept thinking what am I going to do, kill him or just ask him to sleep with me. Then I got the idea this is a crazy thing to do and you aren't going to get away with it. I decided when he would come, I would give myself up. I would show him the gun and the knife. Then I sat down and wrote a note to my parents and asked them to forgive me because if I turn myself over to Waitkus, he would call the police and I would go to prison. Then I sealed the letter and put it on the dresser. After a couple of minutes I changed my mind again and decided to kill him. That was what I thought most about anyway, and I waited for him until about 10:30. Then again I decided he isn't going to come anyway and there is no sense to this and so I went to bed and figured I would leave

the hotel the next day without seeing him. Well I had no more than got to sleep and a little later I was awakened by the telephone ringing. It was Waitkus. Well, he wanted to know what the note was and everything was about and why I wanted to see him. He said, "What's so darn important?" and that shocked me. I hadn't figured a guy like him. I didn't expect that from a guy like him. I thought he would ask me what is it all about but he was so informal. I said I can't discuss it over the phone with you. I asked him if I can't see him tomorrow and he said, "no." Then I said, can you come up tonight for a few minutes? He said, "yes." I said give me a half hour to get dressed. Well, I got dressed and waited for him. I remember when he knocked on the door, I was scared stiff but I thought to myself I would settle this once and for all and really kill him. That time I had a knife in my skirt pocket and I was going to use that on him. When I opened the door he came rushing in right past me. I expected him to stand there and wait until I asked him to come in and during that time I was going to stab him with a knife. I was kind of mad that he came right in and sat down and didn't give me a chance to stab him. He looked at me surprised and said, "What do you want to see me about?" I said wait a minute I have a surprise for you. I went to the closet and got out the gun. I took it out, pointed it at him and he had such a silly look on his face. He looked so surprised. I was pretty mad at him so I told him to get out of the chair and move over by the window. He got up right away and said, "Baby, what's this all about?" That made me mad. He just stood there stuttering and stammering and he asked me again, "What is this all about, what have I done?" and I said, for two years you have been bothering me and now you are going to die, and then I shot him. For a minute I didn't think I shot him because he just stood there and then he crashed against the wall. For a minute I just looked at him. I didn't believe he was shot. He kept saying, "Baby why did you do that?" and then I said, I don't believe I shot you, because he was still smiling. Then I knelt down next to him. He had his hand stretched out, I put my hand over his. He said something to the effect, "You like that don't you?" I took my hand away from his when he said that and I asked him where have you been shot. I couldn't see a bullet hole or blood or anything. He said I shot him in the guts and I was convinced he was shot. I don't know why. I thought, well, now's the time to shoot myself and I told him that, and then I tried to find the bullets but I couldn't find them and then I lost my nerve. I was frantic by that time and I called the operator to call the doctor. When he kept moaning, "Why did you do it, oh baby, why did you do it?", he was groaning and I didn't like to hear it. So I went out in the hall and waited for the doctor. The doctor came and the police. After the doctor came the house detective came too. It was so silly, nobody came out of their rooms. You think they would come rushing out. I got mad. I kept telling them I shot Eddie Waitkus but they didn't know who Eddie Waitkus was. I thought they were just plain dumb if they didn't know who Eddie Waitkus was. I stayed out in the hall with the house detective. After a time they brought out Eddie on a stretcher and he smiled at me. After that police came, but I was burning because nobody was coming out of those other rooms. The nurse who was with the doctor asked me if I wanted anything for my nerves and I told her no. I was feeling better than I had ever in my life. Nobody seemed to want me much, I could have walked right out of the place and nobody would have come after me.

She discussed how Eddie influenced her:

I did see his name on a piece of soap. His number used to be 36. I used to see 36s everywhere. In a show one day a big 36 appeared. It was the Paramount News in its 36th year. On January 27—I celebrated every 27th of the month because that was the day I saw him—on this particular January 27, I saw his picture and he was holding a gun. Well, I thought the whole thing was pretty significant of what I was going to do. Those are the ways I knew he was with me. He is with me in jail, mentally I can recall him any time I want to. We talk about the whole thing. I said, what are you going to do about me now? You wanted me to do this. He usually answers my questions. This time he evaded me. Finally he said, to me, "Don't you think it would be better to go to some hospital?" I told him I would rather do time in Dwight than go to a psychopathic ward. I kept asking him how he felt about the whole thing but he kept evading me so I got mad and wouldn't talk to him the rest of the night. He never suggested sex. He wanted me to come and see him. I'm going to say what I think—not what he tells one to tell. I'm not insane. I'll probably go to the Psychopathic Hospital because I said he is with me but it isn't fair. He should get me out of this mess. He got me in, now let him get me out, but not to put me in a mental hospital. If the charges are dropped I will go home. I didn't want to kill him, not his real self not the self that was with me. His unconscious self. There are two parts of him, his other self does know he is with me. The man himself doesn't know anything about this. It doesn't do anything to me, it just walks and talks and keeps me company. He's like an invisible friend. I wanted to go to Boston. He comes from around there. The idea of going to Boston was to get myself in prison then I couldn't do anything to him. I had many ideas but the main one was to kill him.

When questioned about the next time: "If I ever get out of here I'll kill him for sure if he ever got married. He's the only one worth shooting. I wouldn't shoot anybody else."

On June 30, 1949, a diagnosis of schizophrenia was reported to the Felony Court and that she was committable to an institution for the mentally ill. She was immediately bound over to the Grand Jury who in turn indicted her. A few minutes after the indictment was returned before His Honor Judge James J. McDermott, Chief Justice of the Criminal Court, her attorneys George Beiber and Michael Brodkin requested a sanity hearing and she was found insane [5] by a jury of 12. She was committed to the Department of Public Welfare and sent to the Kankakee State Hospital to remain until she is totally and permanently recovered.

[5] The test to be used before trial is: "He is not considered a lunatic or insane if he is capable of understanding the nature and object of the proceedings against him, and if he rightly comprehends his own condition in reference to such proceedings and has sufficient mind to conduct his defense in a rational or reasonable manner, although upon some other subjects his mind may be deranged or unsound." Freeman *v* People—4 Denio, 9 (N.. Y.).

CLINICAL VARIANTS OF MORAL VALUES[1]

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One of the most potent, almost magic, influences exerted on our lives today is that of scientific language, popularized scientific terminology, catchwords. The magic of a catchword is difficult to overcome. It always appears in the guise of something substantial, respectable, unquestionable, authoritative, and impartial.

Take the word "scientific." The label "scientific" pretty nearly hypnotizes our contemporary. "Scientific" means accurate, precise, correct; it also means dispassionate, objective, totally unprejudiced; it means conservative and workable; it means smoothly and accurately running, a technological achievement; it means purely rational and factual, devoid of imaginative liberties and of that contemplative preoccupation with the inner meaning of things which the *scientifically* prejudiced calls, disparagingly, "philosophical," metaphysical, fantastic. "Scientific" also means measurable, reducible to simple mathematical relationships; if you deal with matters you cannot measure, you are not scientific, you are just "speculative."

Medicine is rightly proud to have become scientific, and in its devotion to measured and measurable precision it rightly boasts of its impersonal accuracy and objective dispassionateness.

However, psychiatry, ever since it cleaved away from theology and philosophy and joined its rightful older sisters, medicine and surgery, has found itself at once in difficulty. It has aspired, as it should, to be scientific, but—dealing as it does with human emotions and social and personal philosophies—it cannot always deal with measurable things. You cannot, for instance, express a sense of guilt in percentages; you cannot measure the depth of despair or the height of satisfaction in yards or in so many light-years. This fact in the eyes of some makes clinical psychiatry unscientific. And yet that which is scientific is literally imbued with a kind of self-righteous fantasy: it is the product of what we call a working hypothesis which is at least at first "pure intuition," that is to say, pure imagination. It is also and always influenced by various personal equations which are but very respectable names for subjectivity and all sorts of personal biases, and most of all by the bias in favor of measuring everything and reducing everything to all sorts of arithmetical equivalents.

I do not think I am too far from the truth if I say that to be scientific means to follow certain established, rather rigid conventions. But if one does not follow these conventions one can yet remain scientific in still another and perhaps the most important sense: in the sense of being constantly in search of the truth and fearless as to how much the truth, if and when found, might contradict and refute the truth as it appeared to us theretofore to be.

There is a great deal of confusion on this subject of being scientific and therefore shying away from everything that is not measurable, such as moral and religious values, for instance. In this respect we fall into the same error as those who have objected to psychoanalysis because of its alleged subjectivism, only because psychoanalysis was so much interested in the subjective experiences of the patients whom it wanted to study. "Subjectivity" became another catchword and served as a rather poignant example of how catchwords can become screens for prejudice and stiflers of truth. For the criticism of subjectivity began to mean two things at once: it is bad to be subjective in your study of a patient, that is to say, to read into the patient your own biases; it is also wrong to study the subjective state of the patient, which he subjectively perceives, because it makes him more introspective, hence more subjective, and you cannot supposedly study objectively that which is subjective. Nothing can be further from the truth, of course. Subjective states are no less real than anything else that is real, and if these subjective states are potent factors

[1] Read at the 105th annual meeting of The American Psychiatric Association, Montreal, Quebec, May 23-27, 1949.

in human behavior they are as much or more dynamic forces as any other external forces. Therefore it is not at all subjective to study subjective states; in other words, it is quite "scientific," *i. e.*, objective, to probe into that which is subjective.

The above may appear both confusing and obvious to the psychiatric clinician, but it bears frequent restatement since our so-called scientific attitude in psychiatry, which requires tolerance and objectivity, has begun to show signs of considerable confusion whenever the problem of moral values is raised. As a matter of fact, a catchword—borrowed this time from psychoanalytic terminology—has come into vogue covering either our reluctance to consider, or our ignorance of the pathological gyrations of, moral values and the moral values themselves. This catchword is known as the "super-ego," a word which has come to designate everything from a healthy conscience to the pathological sensitivity which we encounter in suicidal depression. And yet another catchword has become coupled with this: "to have it analyzed." "You ought to have it analyzed" has come popularly, although not admittedly, to mean to abolish it, to remove it, to destroy it in, *i. e.*, within, yourself. A great many fallacies are involved in this silent philosophy of the loud use of catchwords. First of all, psychoanalysis does not abolish anything, ever; it always leaves the individual with all he had when he first came to be analyzed. It merely makes him aware of the pathological distribution of his affects, and it reorients this distribution. It does not even do this much; it is the patient himself who does the reorienting. If psychoanalysts could really "analyze out" a human conscience, they would have become the greatest mass producers of schizophrenic criminals. This is self-evident, although it cannot be demonstrated by means of figures or graphs; and yet it is true and fundamental and therefore scientific in the best sense of the word.

Somehow it has become an almost universal error to confuse conscience with super-ego, and the super-ego is looked upon by implication if not by stated assertion as a pathological or at least not entirely normal force which interferes with the normal and free exercise of one's living forces and powers. In other words, a sense of guilt is looked upon as a neurotic feeling, and conscience is not taken seriously unless looked upon as a moral category which should be left almost completely outside our psychotherapeutic considerations, except in so far as we ought to endeavor to free the individual from the sadistic pressure of the super-ego.

Now, all this is general and diffuse, to be sure, yet it is rather a clear statement of a widespread point of view. Let us make note of it, and turn for a moment to one other general consideration. Let me cite an example which in passing I mentioned elsewhere some time ago. Let us take the convinced historical materialist, the uncompromising Marxian. To him everything is economics, or economics is everything, as far as human behavior is concerned—individual or social. In other words, everything is strictly determined by economic motives, and the Marxian is a strict historical determinist. It is an open secret, of course, that the Marxian and the Presbyterian both fell into the same pitfall, in which predestination is an incontestable fact but free will is nevertheless also insisted upon as a fact "more or less." But the Presbyterian at least admits quite frankly that he is after goodness and justice and salvation. The Marxian, on the other hand—strict economic determinist that he is—describes in minutest detail the economic (historical) laws of exploitation of the working man, who gets for his work less than his work is worth and thus becomes the victim of a systematized robbery in which the capitalist, the absentee owner, assiduously, inexorably, inevitably, determinately, and predeterminately deprives the proletarian of his real compensation. Let us agree with the Marxian that the theory of surplus value is absolutely correct, that the theory of historical materialism and economic determinism is correct, unchallengeable. And let us then ask the Marxian why he fights for the establishment of the economic kingdom of heaven on earth. Why should he fight for it, since he himself presents economic exploitation and economic acquisitive motivations as the laws of history? Why fight against something which

is proclaimed by the fighter himself as the law of history, the law of man and his society?

The Marxian who would be asked these questions would be the first to be baffled and consider the questioner a fool. Why—he would say—this may be the economic law of history, this may be the historical law of economics, but it is *unjust* to exploit the poor who do not own their tools of production, it is *unjust* to enslave the true producer with the chains of absentee ownership. We will agree with the Marxian that it *is* a frightful injustice and ask him to give us the economic, Marxian, nonabstract ethics of his conception of justice. And he will be hard put to say anything unless he admits that he accepts implicitly the need for a perceived justice which neither Marx, nor Freud, nor rational science, nor Darwinian biology, nor biochemistry would be able to define.

Let us stop at that, for to pursue our main argument it is not really necessary to go any further than to demonstrate that the sense of right and of justice, the sense of social guilt, the sense of expiation of this guilt, is implicit in the work of the most materialistic reformer and revolutionist and the most scientific rationalist, to whom everything in this world is a mass of so many mechanisms mechanistically arrived at. We need not here delve into the origin of the sense of justice which moves the Marxian or any one of us. The establishment of the fact suffices here. Are we to consider the Marxian a neurotic who suffers from a severe pathological sense of guilt of which he wants to relieve himself by his revolutionary rebellion and by his overcompensatory materialistic determinism? These are so many words, words from our current psychopathological vocabulary which may be true in a general, vague sort of way but which in no way relieve us from the recognition of the fact that the sense of injustice, the sense of guilt, the moral sense, is not always neurotic or psychotic, and that even the most crass materialist is not free from this sense of guilt.

This being the case, it is necessary to reiterate what appears to be obvious but what seems to be overlooked: the sense of guilt which we meet in our clinical work is not always pathological, and it is important in every case to make a differential diagnosis of this sense of guilt. The neurotic sense of guilt does not come from that which I would consider conscience and which I think ought to be differentiated from the super-ego. One cannot repeat too frequently that these two seemingly similar psychological agencies are actually different. How and in what respect they are different will be left for consideration in a future paper. Here it will suffice to say this: the sense of guilt of the depressed person who accuses himself of being worthless is perceived by him not for the reason of his having done something wrong but for the reason of his having unconsciously wished to do something he unconsciously considered wrong. The neurotic character who defeats himself each time he is about to succeed defeats himself not because he is unworthy of success, but because unconsciously he considers himself unworthy of success, since unconsciously success means to him many things, from incest to murder. The compulsion neurotic who goes through endless gyrations to undo what he wants to do and to conceal from himself what he cares most for, who gives up many a good thing in life because of his unconscious fear of doing what he wants to do, this compulsion neurotic feels guilty not because he has done something wrong, but because he considers (unconsciously) wrong that which he (unconsciously) wants to do.

In other words, if I were asked to state what the most salient characteristiscs of the pathological sense of guilt are, I would say that in the pathological sense of guilt the intent, even unconscious, and the deed are equated, and that the person reacts to the unconscious intent as if it were an already accomplished misdeed. This is how the super-ego functions. And this is true of all psychopathological reactions, from the mildly neurotic to the severely psychotic ones. It is wrong to equate these reactions of the sense of guilt with the sense of guilt which is related only to accomplished deeds, and with the preventive sense of guilt (the embarrassment and discomfort) which characterizes the healthy reaction of conscience. Conscience, therefore, even though it may utilize the super-ego formations to express itself, is *not* the super-ego, and the super-ego,

even though it may utilize the vocabulary and the mechanisms of the conscience, is *not* the conscience.

General and abstract as these considerations might appear, we ought not to be unmindful of the fact that they are of utmost clinical importance. For of recent years we seem to have fallen into the general error that all sense of guilt is neurotic, all conscience reactions are super-ego reactions, and that not to feel guilty is the ideal of normalcy. It is this almost unconscious, purely philosophical error into which we have drifted that has made us a prey in the hands of those who would attack psychiatry and psychoanalysis for their alleged godlessness and immorality. The psychiatrist is not concerned primarily with moral problems, but he does not reject them any more than the Marxian rejects the concept of justice. And the psychiatrist, being supposedly a more candid psychologist than the Marxian, should admit that he cannot and does not function without moral values, and that moral values are as much a part of him as his own psychology is a part of his total functioning in life.

The principle is a simple one: we want to relieve our patients of the sense of guilt for things they have never really or wittingly done, and we leave them with the conscious sense of guilt for things they *have* really done. As a matter of fact, we could not relieve them of this real sense of guilt even if we wanted to. Those who impute to us the possession of this magic power do so only to attack in us the figure of their own imagination of what a psychiatrist or a psychoanalyst is. The purely clinical manifestations of moral values have as a rule nothing to do with real moral values. They are guilts expressed in terms of moral values. Real moral values are nonneurotic; they are healthy.

THE RORSCHACH DIAGNOSIS AND INTERPRETATION OF INVOLUTIONAL MELANCHOLIA [1]

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The Rorschach Test is being gradually accepted by psychiatrists as a valuable aid in the differential diagnosis of mental disease. Rorschachists are being handicapped, however, because the normal Rorschach findings of the less common forms of mental illness have never been published. Usually the worker in this field has to determine the norms for himself from a detailed study of typical cases. Finding typical cases is much more difficult than might at first seem apparent. So-called typical ones may turn out to be very atypical in a few weeks or months.

Obviously a psychiatrist is not interested in the confirmation of diagnosis of usual, textbook, or advanced cases. Usually these types can be diagnosed on sight or after a brief examination. The difficulties arise in the atypical cases and it is here that the Rorschach diagnostician can be of service.

It is felt, by some trained in this technique, that the diagnosis should be made only after a detailed study of the anamnesis and the clinical findings. The writer disagrees and feels that the test should be able to stand on its own merits. It should be given blind; that is, either the Rorschachist should only interpret and not actually administer the test, or, if he does administer the test, care should be taken not to question the subject about his mental symptoms, otherwise his opinion may be biased.

In a previous publication [2] the writer took up in nontechnical language the differentiation between psychoneurosis, psychopathic personality, and schizophrenia. The Rorschach picture of involutional melancholia is quite different from any of the above three. It will be described in nontechnical language so that those unfamiliar with the test will not be burdened by numerous symbols. Clinically, it is sometimes confused with the organic psychoses on the one hand and certain neurotic pictures on the other. From the Rorschach standpoint these will also be the main syndromes to be considered in the differential diagnosis, especially the former.

Over a period of years a group of 13 cases of involutional melancholia that showed a typical symptomatology were selected for study. The test were done soon after admission to the hospital. What are the Rorschach findings and what do they mean?

The mental retardation that is so often evident on clinical examination reveals itself in a decreased number of responses to the 10 inkblot cards. The average number found in this series was 12, which is a little over one per card, while in the mentally healthy the average number is 25.

The responses will be given usually to the whole inkblot, sometimes to larger details, but only rarely to minor details. This is indicative of faulty concentration and attention. The patient is so disturbed on account of his illness that attention is paid to only the larger, more obvious aspects of his environment. Usually about 25% of the responses in the normal individual are to the whole blot and indicates the ability of the subject to do abstract thinking. In involutional melancholia it indicates rather an inability to do concrete and practical thinking.

Most records will show at least one response that is irrelevant [3] and farfetched. It will be impossible to place much correlation between it and the whole blot or detail responded to. It indicates poor judgment and also perseveration, as often the irrelevant response has been given to the preceding card. This failure to interpret correctly factors in their environment is responsible for the illusionary and phobic symptoms that are frequently found. Normal subjects never give this type of response. Rarely will there be a combination of details to form something meaningful. This shows the difficulty the patient has in planning and organizing any but the simplest of ideas.

Little or no creative ability, which is revealed by the human movement [4] responses,

[1] From the Binghamton State Hospital, Binghamton, New York.

[2] Am. J. Psychiat., **105**: 381, Nov. 1948.

[3] Designated by Rorschachists as an F— response.

[4] Movement may be active or passive. In the

will be present. Usually there will be no response of this type or at the most one. If 2 or 3 are present be very hesitant about making a diagnosis of involutional psychosis. So much introspection concerning the bodily state exists that creativity is stifled.

The color responses,[5] which indicate the status of the emotions, are quite variable. In 8 of the 13 cases, none was present. The rest varied from 1 to 4. What color responses are made are usually based on the actual color rather than the form of the blot. Especially when found in conjunction with animal movement responses it indicates lack of emotional control. Clinically this is seen in impulsive attempts at suicide, crying, and irritability.

An important feature is the predominance of either animal or anatomical responses. If the latter they usually relate to the internal and more especially the urogenital-anal organs. The content of these is usually disguised, as indicated by the following examples: "bottom part of a person," "closed position," and "flabby part" (meaning buttocks). Responses such as spine and vertebra are also frequently used. The preoccupation with their own problems and their own body in particular, the feelings of guilt in regard to sex matters, and their anosadistic inclinations prompt responses along this line. Involutional cases give animal responses as they are the easiest and require little imaginative effort, an asset which they definitely lack. Normal individuals do not give over 50% animal responses and usually much less, whereas involutionals may give 100%.

A very important factor invariably found is the depreciatory side remark that is used in a qualifying manner. Involutionals have little confidence in themselves, are always making excuses, express doubt, do not have the courage of their convictions, and usually judge themselves to their own disadvantage. Expressions such as the following are always seen: "could this be," "don't know what to say," "something like," "does it represent something," and "I don't think I have got it right."

The paucity and rigidity of thought and the lack of originality are revealed in the stereotypy from one card to another. Once they fit their thoughts to the blot it is difficult for them to change the idea even though the succeeding blot may have an altogether different form and outline. This stereotypy usually takes the form of simple animal responses such as bat, insect, or butterfly.

In many cases there is a predilection for certain responses which are not ordinarily used in any other type of case. The three most frequently given are bug, fly, and chicken. Of 13 cases, 7 used these terms. Only rarely are these found in the Rorschach protocols of other mental dieases and they seem more peculiar to involutional melancholia. Probably the patient's sensitivity to contamination comes out in this fashion.

In making the diagnosis the main findings are stereotypy, predilection for the whole response, lack of movement, depreciatory side remarks, and the predominence of animal and anatomical responses. Secondary findings are the number of responses, presence of color form, and the irrelevant response.

The administration of this test to mentally ill patients takes, on an average, only about 30 minutes. This is much less than the average time required for normals. The diagnosis will be apparent usually on completion of the test and further study of the record will not be necessary. No detailed psychograms for the listing of number, types, and percentages of responses are needed, unless an evaluation of the personality is also desired. The only printed form necessary is one with the blots stamped in black and white ink, which facilitates the location of the response, a continuous line being drawn around the whole or detail responded to.

Most psychiatrists dislike administering psychological tests as they are too time-consuming. The administration and the interpretation of the Rorschach Test, for diagnostic purposes only, takes a minimum of time yet gives a definite laboratory check as to the type of mental illness. It should be used in all cases where a differential diagnostic problem exists.

latter, muscular energy is expended but no actual movement in space is present; *i. e.*, man with his arms in the air or someone trying to lift something.

[5] The mature color response, which indicates stability, places more emphasis on the form or outline of the blot and less so on the actual color.

LUNG ABSCESS AS A COMPLICATION OF ELECTROSHOCK THERAPY[1]

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Introduction

In a review of 2,562 cases treated by electroshock therapy during the years 1941-1948 at a large state hospital, 25 cases of pulmonary abscess were found to have developed concurrently with or shortly after the course of therapy. The average course of treatment consisted of 20 grand mal seizures, with a total of approximately 50,000 treatments. Some patients, however, received less than 5 treatments while others received as many as 65.

Although the number of lung abscesses constitutes approximately 1% of the total number of patients treated and about 1/20th of 1% of the actual number of treatments given, this complication was felt to be one of the most serious met with. As substantiation for this fact, it was noted that 5 of the 25 cases died while 10 retained some residual signs or symptoms. This was in contrast to only 3 other deaths recorded in the series due to causes other than lung abscess.

Surprisingly, no cases of lung abscess associated with electroshock therapy have been reported in the American literature up to the present time, although Kalinowsky and Worthing(1) briefly mention the occurrence of one lung abscess in a series of 200 cases of schizophrenia treated by electroshock. For the above reasons it was felt by these authors that the complication of pulmonary lung abscess warranted further study.

To evaluate the 25 cases in which this complication occurred, the clinical records were reviewed, although some of the records were not complete enough for thorough study.

Description of Technique

Minor changes in technique of administering electroshock therapy occurred during the period 1941-1948. When treatment was started late in 1941, the patient was placed on his back on a stretcher with a pillow beneath his shoulder blades. Three attendants assisted—one held each shoulder and one held the knees of the patient. The physician administering the treatment inserted a cotton gag on each side of the mouth on the lower teeth. This allowed for freedom of movement of the tongue but did not allow the patient to close his mouth or bite his tongue. When the convulsion was over, the patient was moved from the stretcher and placed in the bed face down with his head turned to one side.

In 1943 a rubber heel was substituted for the cotton gags. The heel was held in the patient's mouth until the latter part of the clonic stage of the convulsion when it was withdrawn. There were times, however, when the heel could not be withdrawn and the patient retained it for several minutes.

During the early part of 1943 patients were moved from the stretcher to the bed and always placed face down. In the latter half of 1943, because of lack of help in the hospital, and because patients could not be watched as closely, they were put to bed lying face up after treatment to avoid danger of suffocation from burying the head in the mattress. No pretreatment medication was given.

Treatments were also started early in 1942 on other services, and this work was done by various doctors. Techniques varied but essentially agreed with what is described above. Three cases of lung abscess occurred in 1941 and 1942, during which time cotton mouth gags were used and patients were turned on their face. During this same pe-

[1] From the Treatment Unit of Rockland State Hospital, Orangeburg, N. Y. Read at Downstate Interhospital Conference, New York State Psychiatric Institute, April 20, 1949.

riod, 192 cases were treated by electroshock therapy.

Analysis of Data Obtained from Clinical Records

An attempt was made to examine certain variables occurring in this group with the hope of gleaning some suggestions as to possible predisposing or etiological factors.

1. *Age.*—Fifteen of the 25 with lung abscesses were over 40 years; 7 were between 30 and 40 years; and 3 were under 30 years.

2. *Sex.*—Twelve patients were males and 13 were females.

3. *Chronicity* (length of hospitalization before electroshock).—Six patients were ill for over 5 years. Of these, 1 was hospitalized for 19 years prior to treatment while the other 5 were hospitalized for 12, 11, 8, 7, and 7 years respectively. One case was hospitalized for 2 years, 10 months, and 1 case for exactly 2 years. Five cases were in the hospital between 1 and 2 years prior to treatment, while 12 received treatment before they had been hospitalized a full year. Ten of this latter group had actually been hospitalized for less than 4 months prior to receiving therapy.

4. *Number of Shock Treatments Administered to Patients.*—One patient received 65 treatments given as 3 separate courses before the development of an abscess, while at the other extreme 1 case developed an abscess after only 2 treatments. Three of the group of 25 had less than 5 treatments; 4 had from 6 to 10; 12 had from 11 to 20 treatments; and 6 patients had over 21 treatments, either in one, or several, courses of treatment.

5. *Behavior Status of Patients Prior to Treatment.*—Of the 25 patients, only 3 were considered to be clean, tidy, and cooperative. The remaining patients were disturbed, overactive, and untidy in their personal appearance. Seven of these required tube feeding, but the tube feeding was not obviously related to the development of abscess.

6. *Diagnosis.*—Seventeen patients were cases of schizophrenia. Of these, 5 were hebephrenics, 6 catatonics, 5 paranoids, and 1 mixed. There were 2 cases of involutional melancholia; 2 involutional paranoid; 1 cerebral arteriosclerosis and 1 reactive depression; 1 manic-depressive, manic; and 1 alcoholic psychosis, paranoid.

7. *Length of Interval Between Last Shock Treatment and Development of Abscess.*—Twenty-two of the 25 cases developed their first symptoms of lung abscess within a month after their last treatment. Thirteen of these showed symptoms within a week following their last treatment. Three other cases were included after close study because it was felt that the abscess could only be attributed to previous therapy. One case that had had but 2 treatments was found to have a lung abscess 4 months after treatment. This patient recovered from his psychotic episode after his second treatment and shock therapy was therefore discontinued. Shortly thereafter he went to work in the hospital commissary and lived on a convalescent type of ward. Apparently his lung condition had been present for some time before it was discovered by X-ray since he was not closely observed and did not complain.

The other 2 cases were discovered 7½ months and 1 year after treatment. Both of these cases had a pneumonia immediately following treatment which apparently never healed completely, and these patients subsequently were discovered to have a lung abscess.

8. *Location of Abscess.*—Thirteen of the abscesses were located in the right upper or middle lobe; 5 in the left lower lobe; 4 in the left upper lobe. The location of 3 abscesses could not be ascertained from the records available.

Treatment of Abscess and Results of Treatment

All the cases were treated with sulfadiazine, penicillin, or both. Surgical treatment was also used when indicated and where the patients' mental status was such that they could cooperate. Nevertheless, 5 patients died; 1 is still active after thoracotomy and lobectomy; 8 are inactive but show evidence of cavitation by x-ray; 1 shows residual organization and fibrosis; while 10 show complete healing by x-ray.

Discussion

The question arises whether 25 cases of lung abscess among 2,562 patients (an inci-

dence of approximately 1%) is significantly greater than the incidence of lung abscess among the total hospital population. It is obvious that a group of psychotic patients, many elderly, and in poor physical condition will have a much higher incidence of lung abscess than the general population. To evaluate this, all cases of abscess that were not due to electroshock but which occurred during the same period were collected. There were 36 cases, 4 of which might have been due to electroshock therapy but were excluded because of the questionable relationship. Of the remaining 32, 17 can

TABLE 1

CAUSES OF PULMONARY ABSCESSES DURING 6-YEAR PERIOD FOR ENTIRE HOSPITAL

Electroshock therapy	25
Previous infection	6
Chest neoplasm	4
Convulsive states	4
Postsurgery complication	2
Foreign body	1
Metrazol therapy	2
Insulin therapy	1
Cloetta sleep treatment	1
Routine tube feedings	7
Catatonic stupor	2
Alcoholism with malnutrition	1
Unknown causes	1
Four cases not included in series with electroshock treatments because of questionable relationship to electroshock therapy	4
Total number of abscesses from all causes	61

be attributed to a predisposing illness; 6 had a previous infection; 4 chest neoplasm; 4 convulsive states; 2 followed surgery; and 1 had a foreign body in the lung. Four others developed abscess following other somatic therapies; 2 while receiving metrazol; 1 insulin; and one the Cloetta sleep treatment. The remaining 11 occurred without obvious predisposing illness in cases that were typical of the general hospital population. Seven of these were tube-fed; 2 were mute and inaccessible; 1 an alcoholic with malnutrition and 1 described as disturbed and uncooperative. During the same period, the average daily census varied from 6 to 8 thousand and the total patients hospitalized was approximately 19 thousand. From this it is apparent that the incidence of lung abscess is considerably higher among the electroshock group than in the general hospital population. Consequently, it is felt that the abscesses cannot be explained solely on the basis of such general factors as disturbed behavior, malnutrition, and poor dental hygiene. A significant number in both groups were tube-fed. Among the general hospital population the abscesses often followed an obvious intubation of the trachea with fluid entering directly into the lungs. These obvious cases were eliminated from the shock group although it must be pointed out that unrecognized tracheal intubation or regurgitation with aspiration might have been responsible for the abscesses in some of the 7 cases receiving electroshock therapy and also being tube-fed.

The findings are even more startling when one evaluates the clinical course of these cases. Five of the 25 died, and 10 others did not show complete healing despite adequate medical and surgical treatment, probably due to difficulties in properly treating psychotic patients through their inability to cooperate. The 5 deaths represent 62% of the total ECT deaths during the same period, as there were only 3 other deaths resulting from this therapy. One died from suffocation by burying her head in the mattress; 1 died from a coronary occlusion occurring one-half hour after treatment and presumably due to the previous convulsion, and 1 died after electroshock treatment combined with curare. During this same period there were only 20 other serious complications exclusive of minor compression fractures and those complications mentioned above that ultimately led to death.

From a surgical standpoint, the location of the abscesses is worthy of note with the predominant number located in the upper lobes and in the right lung. It is generally stated that the lower lobes are likely to be involved. However, the work of Brock(2) and others show that aspiration in the supine position does involve the upper lobes more frequently, particularly on the right. He cites evidence that lipoidal injected into the nose while the person is asleep will be aspirated into the lungs, particularly the right upper lobe. This seems to us to be the most logical explanation for the etiologic mechanism of lung abscess in electroshock therapy.

At the onset of the study, it was hoped that some correlation could be made between the technique of administering shock therapy and the incidence of lung abscess. The report by Titeca(3) suggested that mouth gags might play a rôle and common sense suggested that placing the patient on his back might increase the chances for aspiration. However, as many different doctors, using slightly different techniques, administered electroshock therapy, definite conclusions could not be drawn from this series although there would not appear to be any decided changes in the incidence of abscesses during the various years despite the changes in technique. One point that can be ascertained is that 3 abscesses developed in 192 cases (1.5%) where the patients were placed on their stomachs following therapy and where absorbent cotton gags were used during therapy. On the other hand, 22 cases out of 2,370 patients (.9%) developed abscesses while usually, but not invariably, being treated with rubber heels as mouth gags and placed on their backs following treatment. Whatever part the variation in treatment technique played in predisposing to development of lung abscess, it must have been overshadowed by other factors.

Of all the other factors evaluated, it would seem that age and disturbed behavior were the most significant determinants found in this study. Sixteen (60%) of the abscesses developed in patients over 40 years of age, although less than 25% of the total shock population fell in this group. Three (12%) of the cases occurred in the group under 30 years of age, while this included 50% of the total shock population. Twenty-three of the 25 were acutely disturbed and the other 2 may have been more disturbed than the records indicate. There was no correlation with sex and no obvious correlation with either number of treatments or diagnosis. It is impossible to be certain, because of the many variables, whether there was any correlation between chronicity and the development of lung abscess. Six (24%) of the abscesses developed in patients hospitalized 5 years or more, while this group included only 10% of the shock population. Fifty-two percent of the abscesses occurred in patients hospitalized 1 year, while this group included only 30% of the total shock population. In view of other factors, such as age and behavior, this cannot be considered conclusive evidence that chronic illness predisposed to abscess although the result of very prolonged psychosis with both physical and mental deterioration apparently makes the risk of abscess greater.

The case of lung abscess reported by Conway and Humphry(4) was believed to have been caused by Vincent's angina infection. In several of these cases this was encountered and felt to be significant. It might have been found more often if specific investigation for such had been made in each case. Despite admission dental examination, the subsequent remedial care and periodic checkup, the dental hygiene of psychotic patients in a large hospital is poor. The fact that from 40% to 80% of the cases developing lung abscess seen in general hospitals(2) had dental abscesses or infections emphasizes the importance that dental hygiene must play in the etiology of lung abscess among the shock patients.

Summary

From a total of 2,562 cases treated by ECT during an 8-year period, 25 cases of lung abscess were discovered concurrently with or shortly after treatment. These records were reviewed in an effort to clarify the etiology. All other lung abscesses occurring during that same period were also reviewed for comparison. Of the 25 abscesses that occurred in connection with ECT, 5 deaths resulted and 10 cases retained residual pulmonary signs as compared with 3 deaths due to or associated with ECT from other causes and 20 other serious complications during this same period. The results were compared according to age, sex, length of hospitalization, diagnosis, behavior classification, technique of administering ECT, number of treatments, and time interval between last ECT and development of abscess as well as location of abscess.

Conclusion

In this series of cases, lung abscess was the most serious complication of electroshock therapy in a state hospital population. Although in this study it was impossible to ascertain definite etiological factors, elderly

disturbed patients seemed more prone to develop abscess than others.

From this as well as studies concerning etiological factors of lung abscess from the literature, it would seem to be of utmost importance to prevent aspiration of saliva and to diagnose abscess or pneumonitis as early as possible in order to minimize this complication.

It is suggested that all patients immediately prior to treatment and where indicated during treatment have thorough dental examination aimed at maintaining good oral hygiene. During treatment atropine should be used to reduce salivation, supplemented by suction in cases where excess secretion occurs. While under treatment, patients' temperatures should be taken at least daily and, at the first sign of even minor respiratory symptoms, treatment should be discontinued and x-ray follow-ups taken. The authors feel that, in addition to the above measures, close attention should be paid to maintaining adequate nutritional states, as well as follow-up x-rays upon completion of treatment.

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POSTGRADUATE TRAINING IN CHILD PSYCHIATRY[1]

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I think it will be most valuable in discussing the question of postgraduate training in child psychiatry to indicate the principles that govern work in this department of Maudsley and our practice in respect of training. It should be made clear that we regard child psychiatry in all its aspects and with all its specialised techniques of investigation and therapy as part of the necessary training of a psychiatrist. Further, we consider that the psychiatrist who will specialize on work with children should have a sound training in adult psychiatry. The course in psychiatry of children occupies 6 months full time in the 2 to 2½ years of basic psychiatric training. A year of adult psychiatry is regarded as the necessary preliminary to child psychiatry.

We have here an outpatient department for children in which approximately 500 new cases are seen each year. It is regarded as fundamental that full clinical responsibility is taken for every case investigated and that the work of the department does not cease until every contribution possible, whether in the field of organic treatment, psychotherapy, education, or psychiatric social work, has been made. Parallel with the need for clinical responsibility for the individual we regard it as essential that the department accepts its community responsibility. All cases referred up to the age of 16 years are accepted without selection—up to the 10 or 12 new cases a week that we find we can deal with completely.

We have a clinical teaching programme that applies not only to psychiatrists in training but also to mental health students and psychologists who are having a postgraduate 12 months of training in clinical psychology. In each category it is considered that the best training for the student or psychiatrist in training is to play a responsible part in treatment, with the opportunity of discussion with seniors.

New cases are all made the subject of a conference the same afternoon and all the psychiatrists working in the department are encouraged to attend these conferences.

The mother and child arrive by appointment, and in the ensuing 2 hours the psychiatrist examines and interviews the child and the mother, while the child is also examined by the psychologist and the mother interviewed by the psychiatric social worker.

The psychiatric social worker hears the initial reason for referral and inquires into the total environmental situation from the maternal attitudes to the social and economic conditions. She also takes as far as possible the personal history and family history.

The doctor in his interview with the mother first confines himself to the complaint in detail but then formally covers the present state of the child in respect of developmental habits, emotional attitudes, physical complaints, personal relations, conduct, etc. This formal "present status" is considered as essential to the psychiatric examination of a case as routine physical examination in the training of a medical student. In his interview with the child the doctor obtains as far as possible a subjective impression from the child and makes an objective assessment of the degree of the disturbance. Physical examination is made at this or the next interview.

The psychologist in his examination of the child makes an intelligence test and, if time permits, gives tests of educational attainment, and reports on the child's behaviour in this rather standardised situation.

A brief pause and a cup of tea for all is followed by a conference on the case, when the participants present the material obtained and the senior psychiatrist formulates the problem, further investigations required, and the plan of treatment. In this he has the cooperation of a staff psychologist and psychi-

[1] Paper delivered to the Specialist Meeting, International Congress on Mental Health (London, 1948), on August 20, 1948.

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atric social worker who are always present at the conference; while discussion is wide, and individual expression of opinion or disagreement welcomed, it centres on issues raised by the case under consideration. Prior to the discussion the child comes in and is interviewed by the senior psychiatrist, and subsequent to the discussion the mother comes in and is briefly enlightened as to the conclusions arrived at and what is required in the nature of further attendances, etc. The psychiatrist in training, the psychiatric social worker, and the psychologist then arrange for subsequent appointments.

Treatment may range from short-term friendly relationship with the child and encouragement, to more intensive and prolonged therapy with use of projective and play techniques; or electroencephalogram or neurological investigation may alter the direction of treatment; or the psychologist may deal with any educational difficulties by special coaching, educational adjustment, etc., or make further psychometric investigations; or the psychiatric social worker may engage in helping to modify the social background or individual work with the mother in relation to her attitudes.

During the whole course of the treatment the psychiatrist in training has one to two hours weekly with one or other of the senior staff psychiatrists when the cases are reviewed, problems discussed, or alternative approaches explained and initiated. Similar discussions are held between students and their seniors in the other disciplines. Thus it will be seen that teaching and treatment go hand in hand and, while the interests of the patient are maintained by close contact between the worker and a more experienced individual in the field, the doctor in training learns by direct clinical experience rather than by didactic formulations or theoretical discussion.

While all cases are investigated on a similar plan, a certain differentiation has taken place in the initial conferences. All epileptic children referred to the hospital are seen on a particular morning and the conferences are taken by one of the staff who has trained in respect of children's psychiatry in this department and is making a particular study of such material.

We do not have many defectives referred to us but accept those who are, and they are dealt with in a similar way at a particular conference where the chair is taken by one of our most enlightened and progressive workers in this field and superintendent of a hospital for defectives.

The psychiatrist at the London remand homes is also a "graduate" from this department and is a part-time member of the staff; he may recommend that the Court refer a child to this department for treatment and himself supervise the treatment.

In respect of the latter two specialities, doctors doing their 6 months in the department also spend 20 sessions at our 2 main colonies for high-grade and low-grade defectives, and 12 sessions at the remand home where they see cases referred for investigation by the Court.

A similar grouping has taken place in our treatment activities. We have one hospital registrar, who has completed her initial 6 months in the department and is now on the full-time staff. She takes a children's group for play, and the material there is studied by one of the psychological team.

Another of our "graduates," who takes the epileptic clinic, is making a study of a hyperactive group of children who show an abnormal EEG and respond to benzedrine. (In each case the doctors in training, however, are kept aware of what is happening to their own particular cases.)

One doctor with experience of group therapy has formed a mother's group, which it is hoped will be made a permanent feature of our setup.

A somewhat varied list of suitable reading matter is supplied to each doctor during his period of training, and he is encouraged to read and explore in any topic that may be cropping up in his case material. Fortnightly we have a seminar, when discussion may be initiated by one of the doctors in training who has been studying a topic, or by any member of the staff who has found an article or subject which he regards as of general interest. Or the seminar may be initiated by an outside probation officer, magistrate, or school medical officer, invited to attend.

A weekly general conference on a case of particular interest is taken by one of the

senior pædiatric physicians or by one of the consultant psychotherapists who has particular experience in children's work and who may also supervise the treatment of cases in the department. Alternate fortnights, an afternoon visit may be paid to any establishment where children are treated or cared for.

Our inpatient department accommodates 20 to 30 cases. To this, cases are admitted from our own attendance list when the intensity of the disturbance on the part of the mother or child may require, or for more intensive investigation and treatment, or for the research or teaching value. Each doctor retains in the inpatient department any case with which he has been dealing outside. In addition, doctors during their period of training may spend a period as ward registrar, where the dynamics of a group of children up to 12 years of age in hospital impinges forcibly upon him.

Biweekly ward rounds are held, and again the endeavour is made to keep every doctor in training familiar with all the cases under investigation and treatment. We attach great importance to the training with the doctors in inpatient work. There is nothing better than direct observation and the responsibility of meeting children's needs for inculcating fundamental principles (as well as a realistic attitude).

Adolescents above the age of 12 years are meantime if admitted dealt with in the adult side but the cases remain the responsibility of this department. Two of our "graduates," now on the staff, are particularly interested in this field and each of them will probably have charge of one of the adolescent wards presently to be developed.

During this 6 months course 7 psychiatrists obtain training. I am myself full-time and my senior colleague is part-time. Almost all his time and about one-third of mine is fully taken up with teaching or discussion of cases with the individual doctors. If I may repeat, the principles are complete investigation of all aspects of the child's biological and social existence; complete clinical responsibility for all cases examined; community responsibility for cases referred; education for those in training through meeting the needs of the individual case with assistance from the more experienced. The hours spent in the department by the doctors in training are long but have been justified by the methods employed and the results. The training has produced a well-grounded group of psychiatrists, fertile in individual development, capable of dealing with all aspects of the case, and in some degree experienced in the various techniques in treatment.

While the writer does not wish to place responsibility for the views expressed on any other shoulders, psychiatrists who have had the privilege of working in the service of Dr. Leo Kanner at the Johns Hopkins Hospital will recognize some elements of the organisation.

A PRACTICAL TREATMENT PROGRAM FOR A MENTAL HOSPITAL "BACK" WARD[1]

M. G. MARTIN, M.D., North Battleford, Saskatchewan

This paper tells what was done on a so-called "back" ward of one mental hospital. Every mental hospital has one of these wards for the patients who are deteriorated but physically fit. The public thinks in terms of "The Snake Pit." The general practitioner thinks of these patients in such terms as "the hopeless and the damned." The hospital ward attendant usually feels that work with these patients lacks result, purpose, and prestige. The mental hospital doctor is usually preoccupied with his load of "new" patients, and these patients and their relatives make frequent demands upon his time and attention.

The work to be described was done on one ward with 72 male patients, 8 attendants, 1 supervisor, and 1 physician. Most of the patients were schizophrenics. The average age was 40 years; the average duration of illness was 17 years. Only 5 of the patients worked on the ward and there were no outside workers.

Almost all had arrived in hospital before the advent of electroshock and only a small number had previously received treatment; none was considered to have had a "full" course of treatment(1). During 3 months, 62 patients received 1,117 electroshock treatments—an average of 18 treatments per patient. Using 60-cycle current and an Offner machine, we sought the lowest possible dosage. With the electrodes applied to the vertex and left temporal regions, the usual dosage was 300 milliamperes for 0.5 second. The complications were 1 compression fracture of a thoracic vertebra and 1 avulsion of quadriceps tendon from patella. We did not give electroshock to 10 patients having various organic psychoses.

Before the active treatment program was started, all these patients were housed in a separate building called "The Annex." This was a barren structure that had been built for workshops. The patients assigned to "The Annex" were those least likely to improve. The ward staff was selected from the same standpoint. The results were repulsive. Urine running down the stairs was covered by sawdust. Most of the day, the patients sat on benches, jammed elbow to elbow. The only treatment was recreational; at intervals the patients were paraded around and around in a circle, while the ward staff stood on benches in the centre of the circle and urged them on in the manner of an overseer in a galley driving the slaves to greater effort.

The first step in treatment was the moving of these miserable people to an "ordinary" ward in the main hospital building. We made a patients' "sitting room" by taking beds from a sun porch and supplying chairs. A radio was placed in this sitting room and magazines began to arrive after arrangements had been made with a local school. Flowering plants were placed throughout the ward and every one was pleased when they remained unharmed. The "strong suits" that the patients had worn were replaced by overalls.

This work was done by the ward staff, assisted in their housekeeping by 5 patients loaned daily from other wards. Eventually we were able to send patients to work off the "home" ward.

Occupational therapy did not work out. We tried having the patients rip up burlap bags and tie the strings together. The impression was that other activities were more timeworthy.

In the morning 2 medicine balls were thrown vigorously. The morning walk covered 2 miles. At noon there was another walk and a play interval of 2 hours. During this period, the men played simple baseball or they did gardening chores in the outdoor play area that we had appropriated for them. Once a week they appeared to enjoy a movie show on the ward after supper.

The main treatment effort was directed to influencing the attitude of the ward staff.

[1] From the Saskatchewan Hospital, North Battleford, Sask.

One morning each week a half-hour was devoted to a seminar type of discussion group. Our aim was to motivate and to orientate. We tried to establish efficient two-way communication between doctor and ward staff(2).

The ward staff was told that, if there were to be any favorable results, these would be very modest. We said that we did not expect any patient to leave hospital and that only 5 or 6 could be expected to benefit significantly. The ward staff was told that every "good" result would depend on them. We said that we pushed the button on the electroshock machine solely to make the patients more accessible and suggestible and more likely to copy the behavior of the ward staff. During the talks, repeated emphasis was placed on the contagiousness of behavior. Ward staff was also told that staff on other wards scoffed at the treatment on "our" ward and felt it was a waste of time. The response to this was favorable.

The manner of assisting during electroshock treatments was discussed in relation to complications. Ultimately there was some discussion of the job attitudes of attendants.

The talks started again each month when the shift changed. We were thankful that the supervisor did not change with the shift. There was a close relationship between supervisor and doctor and we felt that the confidence and enthusiasm in this relationship had a strong influence on the other ward staff.

A complete progress note was made on each patient the day before his electroshock was to start. Electroshock was given each morning, 5 mornings a week(3). If confusion occurred, treatments were given twice weekly. A course of 20 treatments was given to most patients and we found 3 patients who showed no response until after the 15th treatment, or later, when they responded favorably. Relapsing patients received a block of 3 treatments given on successive days; if this was ineffective, they were put to sleep for 3 days by means of sodium amytal, given by vein each morning and by mouth each afternoon. We did not find any overactive patients whom we were unable to control.

It was found that the optimum number of patients for efficient handling on electroshock was 20. The treatment of these 20 patients took one-half hour each morning.

Progress ratings were made every 2 weeks in the presence of the entire ward staff. The ratings were made by comparing the status on the day of the rating with the status as rated the day before starting electroshock. The supervisor suggested a tentative rating and this was modified as seen fit by the ward staff, all of whom were present.

RESULTS

The patients rated as improved were those to whom both of the following criteria could be applied:

1. More cooperative and more interested in ward activities.

2. Better toilet habits and better care of self and clothing.

TABLE 1

RESULTS BY DIAGNOSTIC CATEGORIES

	No. treated	No. improved	No. unchanged
Schiz., catatonic	16	6	10
Schiz., hebephrenic	18	10	8
Schiz., paranoid	2	1	1
Schiz., undifferentiated..	14	6	8
Schiz., defective base..	4	1	3
Psychosis with mental deficiency	5	1	4
Presenile psychosis....	1	..	1
G.P.I.	2	..	2
	62	25	37

There are so many variables in this experiment that it does not lend itself readily to statistical evaluation. It seemed that 40% of those treated with electroshock showed significant improvement 5 months later (Table 1). Nine months after treatment it appeared that 60% were improved. At that time 5 patients had been moved to "better" wards and one had gone home. Seven men were working off the ward; 12 had become good ward workers and all had some "work" on the ward. Four of the 10 patients untreated with electroshock had become more interested and more cooperative. Some of the ward staff said that all the patients were improved. Others who did not see the patients until after the first few months of the experiment said that they seemed to be a

different group of patients. Before the active treatment program, 7 staff members had been required to keep order; now 3 could manage the 72 patients on 2-mile walks.

The patients looked better in many ways, especially the 20 patients who now wore shoes and who formerly had been noticeable because of their feet swollen by many years of dependent posture and inactivity. Originally, the daily sick parade had some 24 patients, most of them with leg ulcers requiring daily attention. Now there were only 3 patients on sick parade over an entire week. Before treatment some 48 men wet and soiled their beds every night. After treatment there were only 12 who were steady bed-wetters and 28 who wet occasionally. Replacement of mattresses fell from 90 a month to about 20 a month.

The table shows the results of treatment. Our feeling is that the more significant results were obtained with the ward staff. They seemed to feel that they were part of a special team and they worked as though they were personally interested in the program. The ward no longer looked like a "back" ward and, more important, no one thought of it as a "back" ward.

DISCUSSION

Perhaps the "back" ward active treatment setting is a favorable place to infect new ward staff with job enthusiasm and understanding of mental hospital patients. Certainly it is reassuring for the apprehensive new employee to find active treatment and encouraging results on the ward housing the most deteriorated patients.

SUMMARY

1. Sixty-two patients on a mental hospital "back" ward were treated by electroshock and by manipulation of the attitudes in their environment.

2. At least 25 patients showed more cooperation, better care of self, and better control of activity.

3. The ward staff responded to the treatment program even more favorably than the patients.

4. It is possible to eliminate the "back" ward idea by providing appropriate attention.

I wish to express my gratitude for the guidance of Dr. F. S. Lawson, Superintendent, Saskatchewan Hospital, North Battleford, Saskatchewan.

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NEUROPSYCHIATRY IN MICHIGAN (II) [1]

A Brief Review for Those Attending the 1950 Meeting of The American Psychiatric Association

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As in thought you turn the pages of the history of Michigan your first associations are probably Indians, lumber, and Paul Bunyan. On such mental television screen there will also appear furniture, celery, copper, iron ore, automobiles in large numbers, and yet two other products, peppermint and salt. The latter has been liberally iodized since your visit here in 1943. Before going on to the comments to follow, you may wish to recall and even to consult "Neuropsychiatry in Michigan" (I) which was available to you in 1943 and which may still be found in this Journal (99: 719-731, March, 1943).

Michigan was formally admitted to the Union January 26, 1837, with a population of 87,273. Its census April 1, 1940, was 5,256,106. Its estimated population July 1, 1949, was 6,350,000. Detroit was founded by Antoine de la Motte Cadillac in 1701, almost 250 years ago. Its present estimated population (January 1, 1950) is 1,835,000. Wayne County has a population of 2,375,000 (January 1, 1950).

In the United States, in Canada, and in the world generally, many changes have occurred since 1943. Your attention will be directed to some of the changes in the neuropsychiatry of Michigan.

Among the 403 doctors of Michigan who have joined the caravan of the immortals since you were here in 1943, are Thomas K. Gruber, Max M. Peet, Norman G. Tufford, Henry R. Craig, Hawley S. Sanford, and Nicholas W. Pinto. You will miss them as we are missing them.

Time in the past seven years has wrought many changes in the institutions of Michigan. These changes are worthy of review.

Eloise Hospital and Infirmary (1839).—In 1931 a 500-bed general hospital, the William J. Seymour Hospital, was opened. To further indicate the general hospital facilities of this enlarged Eloise Hospital and Infirmary, the Wayne County Board of Institutions, successor to the Wayne County Superintendents of the Poor, in 1944 renamed it the Wayne County General Hospital and Infirmary. This hospital and infirmary, still operated as a county institution, is now the largest hospital in Michigan. Its patient population is approximately 7000, of which 4000 are mental patients, 500 general hospital patients, and 2500 infirmary patients and indigents. Thirty-three hundred of the 4000 mental patients are state charges housed at Eloise because of the overcrowding in the state hospitals.

To its medical superintendents belong much of the credit for the splendid growth of the institution: Dr. E. O. Bennett, 1881-1900; Dr. John J. Marker, 1900-1921; Dr. J. E. Bennett, son of Dr. E. O. Bennett, 1921-1929; Dr. T. K. Gruber, 1929-1949, and Dr. R. M. Athay, 1949, present incumbent. Particularly, during the superintendency of Dr. Thomas K. Gruber did the institution become a hospital in fact as well as name. During his 20 years of service the general hospital was opened, adequate nursing services provided, all inclusive pioneering in the intensive therapies, occupational and recreational therapy units enlarged, and the psychiatric staff increased from 3 to 22 with direction by a clinical director.

The Eloise Parole Clinic, now known as the Consultation Center, continued in downtown Detroit to provide treatment for mental patients released from the hospital. In 1948 fully 600 extramural patients received follow-up treatment there.

In 1949 the Wayne County Mental Health Clinic was opened, also in Detroit, to provide ambulatory psychiatric services for residents of Wayne County unable to pay for private psychiatric care. In the first year this unit saw 1200 patients at admission and established a caseload of 150 patients in treatment.

[1] From the Division of Neuropsychiatry, Department of Medicine, Henry Ford Hospital, Detroit, Michigan.

By the establishment of these outlying units the hospital approaches its goal of providing a total community service for the mentally ill, namely, adequate hospital facilities, provision for continued treatment after release from the hospital, and community facilities for the ambulatory treatment of the milder mental illnesses of those unable to afford private care.

In the area of teaching and training the Wayne County General Hospital and Infirmary functions as one of the teaching units of the Wayne University College of Medicine, for psychiatry and other medical specialties. Its nine psychiatric residencies are approved for the three year residency period as are the other medical and surgical residencies in the general hospital. Internships in psychology, psychiatric social work, and occupational and recreational therapy are included in its training facilities.

Kalamazoo State Hospital (1848).—On retirement of Dr. Herman Ostrander in 1929, Dr. Roy A. Morter became medical superintendent on January 1, 1930. In 1939 a master plan for the replacement of the older buildings was approved. This plan provided for centralization of all the acute services in a quadrangular arrangement of buildings in the center of the grounds. Funds were appropriated and the construction begun in 1940 was completed in 1941. A new 150-bed modern tuberculosis hospital replaced the old wooden "shacks" which had been in use for about 40 years. A receiving hospital, a hospital for the acutely ill, and geriatric sections for both men and women, provided 558 additional beds. This new construction included administration facilities for the entire institution, provisions for research, and clinical, pathological, and biological laboratories. Modern equipment supplied the physicians with the means and stimulus to satisfy their interests in the physical bases of psychiatric medicine. Research studies in the endocrinology of schizophrenia are being continued. The new construction also provides increased and improved hydrotherapy and recreational facilities with gymnasiums for men and for women directly attached to their respective buildings. In the receiving hospital for women a large class room and library are reserved for the exclusive use of affiliate nurses. The present facilities of the hospital accommodate 3500 patients.

Pontiac State Hospital (1873).—Since 1938, the greatest advance has been the addition of new units. The receiving unit, 350 beds, and the hospital for the treatment of the physically ill, 150 beds, were opened in 1940 and 1941. The new geriatric hospitals for men and for women, 400 beds, were opened in 1949 and 1950.

These buildings have been so constructed as to add greatly to the type of program which has been instituted for improved care and treatment.

To parallel the above building program, there has been a rapid advance in the therapy offered patients and the advanced training opportunities for staff and supportive staff. Lectures by speakers from Wayne University, Detroit hospitals, and other accessible services are delivered regularly to the medical staff, and members of the hospital auxiliary services are urged to attend these scientific lectures. Autopsies and monthly clinical pathological conferences give opportunity for gross and microscopic study of brain pathology.

With a full staff of eighteen physicians, it has been possible to establish group therapy with teams functioning as often as needed. Also, many hours of individual therapy are accorded to patients in a manner comparable to that offered in the better type of private mental hospitals. These increased provisions, established in the past three years, have brought added enthusiasm and willingness to work to all hospital personnel, and improved therapy and morale to a total of 2900 patient population.

Traverse City State Hospital (1881).—Through an enabling act of the State Legislature, the James Decker Munson Hospital was separated from the Traverse City State Hospital, February 28, 1946. It was leased to an executive board representing the citizens of Traverse City and is now operated as a nonprofit community hospital. The reasons for this action were twofold. First, the hospital had become an administrative burden to the Traverse City State Hospital and secondly, expansion of the Munson Hospital unit seemed a dire necessity. The State

Legislature refused to provide the necessary money with which to expand and subscriptions from the public could not be obtained while the unit was state operated.

The Traverse City State Hospital has continued to grow in service. Its admissions and discharges are now double the number that were granted service six years ago. This has been accomplished without an appreciable increase in the bed capacity and hence is a favorable reflection of some additions in the number and quality of personnel and a more vigorous therapeutic program.

Newberry State Hospital (1893).—Its uniqueness of construction is markworthy—two story cottages arranged in a quadrangle and connected by covered porches—and very practical in this northland. A receiving unit of 120 beds for intensive treatment has been added. There is a separate administration building. At this time there is in the process of erection a service building to house bake shop, butcher shop, much refrigerating space for fresh vegetables, dining room for employees, and congregate dining room for patients—dining service by cafeteria. The group of buildings known as the Childrens Unit has not been increased, although there is a long waiting list. It is hoped the incoming Legislature may bring relief. The present estimated valuation of this hospital is $3,231,956; 463 employees; and a total patient population of 1747.

The Neuropsychiatric Institute (1901).—Construction of the Neuropsychiatric Institute, as an integral part of the 1000-bed University Hospital of the University of Michigan, was completed in February of 1939, and the first patients were admitted in March of that year. At that time it was anticipated that the second floor would be used as a childrens unit. Since it was not possible to open the childrens unit for several years, late in 1945 the second floor was altered for adult patients and used as a temporary veterans readjustment center. This function was supported by the state, pending the construction of the readjustment center.

In January, 1947, work was started on the new veterans readjustment center, and the building was completed for occupancy in October, 1948. This is an open unit for the care of mentally ill persons who served in World War II, and are not, or cannot be taken care of in either a state hospital or Veterans Administration Hospital. It is not in any way connected with the Veterans Administration program, except that patients who are admitted to the veterans readjustment center and who have a service-connected disability, have their hospitalization paid for by the Veterans Administration.

In the Neuropsychiatric Institute 133 beds are available for psychiatric in-patients, who are admitted primarily on a voluntary basis. A wide variety of diagnostic entities is represented with the majority in the psychoneurotic group. In the out-patient department of the Institute, over 3000 patients are seen annually, most frequently on referral from the General Hospital. These are chiefly neurotic and psychosomatic problems. The in-patient department is almost entirely a treatment service. Individual intensive psychotherapy, dynamically oriented, is the chief therapeutic procedure, but training in other forms of therapy, including electric shock and insulin treatment is given. The out-patient department is largely diagnostic and consultative but a number of patients are accepted for individual psychotherapy. Exceptional facilities are available in the laboratories of neuropathology and electroencephalography.

During the past few years there has been a marked increase in investigation and in training done. At the present time there are 33 men in training in psychiatry at the Neuropsychiatric Institute. Six of these men are fellows supported by Federal funds provided through the State Department of Mental Health, five are residents in training under the Veterans Administration training program. The others are members of the regular training program of the Institute.

The training program is designed to prepare trainees adequately for the practice of the specialty of psychiatry and for examination by the American Board of Psychiatry and Neurology. The psychiatric teaching staff consists of twelve senior members who spend their full time at the Neuropsychiatric Institute. All major schools of psychiatric thought are presented in the teaching. Training in the various forms of psychiatric activity is given both theoretically and by practical experience.

During the past few years also, there has been a marked increase in the teaching of medical students and much greater emphasis has been placed upon psychosomatic and psychoneurotic disorders and their therapy.

The Ionia State Hospital (1883).—Dr. Perry C. Robertson continues to dispense able management in keeping with the original purpose of this hospital, namely, "To receive insane ex-convicts from the civil asylums who manifest homicidal tendencies; to receive insane convicts from the penal institutions who manifest mental symptoms; and to receive persons under arrest for felonies who are adjudged insane by the Court before completion of the trial of the original criminal charge." Since the enactment of the Criminal Sexual Psychopath law (Act 165, Public Acts, 1939) the concerns of Dr. Robertson have increased greatly, for during the year (1948-49) 89 such patients were admitted. Their remedial care entails much attention. As of July 1, 1949, total patient population was 1077, 990 male and 87 female.

Lapeer State Home and Training School (1893).—It took its present name in 1937. With the death of Dr. Fred R. Hanna, Dr. Robert E. Cooper entered on its superintendency and carried its responsibilities until 1947 when Dr. A. T. Rehn, present superintendent, took over. Resident patient population in January, 1950, was 4300 with a waiting list of 467. About 400 patients were on jobs outside the institution on parole basis.

The program at Lapeer combines home and hospital facilities for those patients who require custodial care and school or work training for those who may become capable of life outside the institution. Ordinarily about 1500 patients are on work assignment, either full time in the institution or dividing their time between institutional work and a day work job. The academic school is designed to provide for all children who can benefit from the program, with a cottage school program for those most limited. The cottage program is being expanded as rapidly as possible so as to provide some training for every patient with sufficient ability.

The Caro State Hospital for Epileptics (1913).—The institution has grown by intermittent building programs until it now comprises a receiving hospital, 17 patient cottages, and associated service buildings. The present enrollment is 1612 patients. An active outpatient service is maintained. The school for educable epileptic children is one of the outstanding features of the institution. With the retirement of Dr. Robert L. Dixon on October 1, 1949, Dr. Willard W. Dickerson, assistant superintendent, was appointed to the superintendency.

Wayne County Training School (1922).—This school is located on a thousand acres midway between Northville and Plymouth. The original purpose of this county-financed institution was to increase the salvage for community usefulness of those higher grade mentally deficient children that are so largely represented in institutional populations. Eighty per cent of the admissions to this training school are from Detroit.

Salvaging rehabilitation is away from the tradition of continuous custodial care, and hence a complete reorientation of understanding with respect to program was required. There was immediate demand for more knowledge of the individual child admitted; more knowledge of what sort of a training program was required to increase the possibility of his rehabilitation for community usefulness; and more knowledge of what sort of a community program best could furnish the necessary continuing external aid and support to the child on his hastened return. The research studies undertaken toward the achievement of this are set forth in many published articles in current journals. Inquiries and reprints are gladly granted. Visitors from all parts of the world continue to come to see at first hand or to study from longer residence the application of the principles worked out into a problem ordinarily considered static.

More than 4000 children have been admitted to the functions of the school since it was opened 24 years ago. The daily patient population continues at slightly over 700. Another group, regularly 400 to 500, are in the community under continuous parole supervision.

Dr. Robert H. Haskell, one time assistant medical director of the State Psychopathic Hospital at the University of Michigan, forerunner of the Neuropsychiatric Institute, and later medical superintendent of the Ionia

State Hospital, has continued as the medical superintendent of the Training School since its founding.

Ypsilanti State Hospital (1929).—Located eight miles southwest of Ypsilanti, its property embraces 1216 acres of land and nine separate buildings. It serves the counties of Wayne, Washtenaw, Jackson, Lenawee, Hillsdale, and Monroe. The present bed capacity is 4000.

An effort has been made so to staff and organize the institution that it will be possible to bring to the patients all the accepted types of therapy offered in private hospitals. Its staff is composed of 21 physicians, two of whom are clinical directors, a full time surgeon, and a physician specializing in internal medicine. The department heads of the Medical School of the University of Michigan act as consultants to this staff. All members of the staff are free to attend lectures and courses at that school and for psychoanalysis if they desire. Prefrontal lobotomies are performed by staff members of the department of neurology, University of Michigan. Research studies are encouraged in line with individual interests. Outpatient clinics are held on schedule at the Foote Memorial Hospital, Jackson, at the Department of Corrections and Paroles, Detroit, and daily at the hospital.

All attendants are given a course of instruction and upon graduation receive a certificate from the Civil Service Commission of the State. Affiliated courses of instruction are given to student nurses, students in social service and in occupational therapy.

During the past few years because of an increasing number of admissions of patients with ages between 8 and 15 years of age, a service program for children has been organized. These children represent the most severe social problems in the community, the majority being either psychotic or primary behavior disorders. It is hoped that in the future even better provisions can be made by the state for their housing and care. Separate buildings or a cottage plan are contemplated. This program of child psychiatry will be enlarged because of its urgency.

Sault Ste. Marie State Hospital (1944).—In September, 1944, the installation known as the Fort Brady Area Station Hospital, was leased by the State of Michigan to relieve the appalling congestion of mental patients in the state hospitals and more particularly to relieve the situation in the Receiving Hospital of Detroit and the Wayne County General Hospital and Infirmary. The buildings are of frame construction and the typical army hospital layout. They are located on approximately thirty acres of land within the City of Sault Ste. Marie. The fire hazard in the frame buildings is, to some extent, offset by the one-story construction, with multiple exits, and a sprinkler system protecting about one-half the buildings. The institution was renamed the Sault Ste. Marie State Hospital.

Patients from all the state hospitals and the Wayne County General Hospital and Infirmary began arriving in March, 1945. They were chronic, custodial cases; ambulatory and not inclined to violence, since none of the windows were protected. Within the next year, the hospital was filled to its capacity of 504 patients. However, in the fall of 1946, the congestion in the Detroit area had again become oppressive and the capacity was increased to 558 beds. The State overcrowding, occurring chiefly among women patients, necessitated a ratio of four female to one male patient here. Fortunately, the hospital plan lent itself to this accommodation.

With a plentiful supply of attendant nursing help, patients did receive excellent care and from the start an active program of recreation was instituted. Occupational therapy in handicrafts was also begun soon after the establishment of the hospital. The small auditorium permitted religious services, movies, dances, and other types of group gatherings. Music therapy was stressed. In summer, patients could be permitted to roam almost at will with limited supervision. They were encouraged to improve the "lodge" surroundings, especially with flower beds. Vegetable gardening was also encouraged, not in farm style, but rather in homelike garden plots. Other services, including laboratory, social service, psychology, and psychiatric graduate nurses, were added at a later date. The medical care was meager at the outset, with only the medical superintendent, Dr. G. D. Woodward, at-

tempting to supply this need, as well as carrying out his executive duties. Dr. Woodward was succeeded in the superintendency by Dr. T. W. Thompson in March, 1946, and it was not until the fall of that year that another physician was obtained. Other physician positions were approved, but it was impossible to attract psychiatrists so far from the metropolitan and teaching centers.

It should be pointed out that the lease from the Army was for a period of five years, terminating September 30, 1949. Shortly before Christmas, 1948, the Army announced its intention to re-occupy the buildings at the close of the lease. However, with considerable pressure exerted by the state, the lease was extended to August 31, 1950. The announcement came in the late Spring of 1949, and there was considerable feeling that the lease might be extended from year to year. However, in November last, the Army firmly insisted on the evacuation of the Institution. The first busload of patients left the Institution on January 27th, and it is planned to complete the evacuation by June 30th, leaving the balance of the time to move equipment.

It was unfortunate that approximately 400 patients were located 300 or more miles from their homes. However, the Institution has supplied the need for temporary housing and the response of the patients to the type of care and treatment was gratifying to the staff. From a total of 687 patients treated in the hospital, ten have been restored to soundness of mind and ten others are on convalescent status. A modest family care program was begun in August, 1946, and forty-three were so placed for rehabilitation. With custodial care in mind, it was found that ninety-five others have improved to such extent that trial was warranted. Their placement is well under way.

Coldwater State Home and Training School (1874).—During the past year two buildings, each with 224 beds for lower grade retarded individuals, were opened and occupied. These buildings of simple one story construction provide many facilities which previously had not been available, such as radiant heat, unbreakable windows, enclosed out door courts filled with play equipment, and aquarium and solarium accessible to the patients from their day room. Funds have been appropriated for a 300 bed nursery, for two 50-bed buildings, one for males and the other for females of delinquent type, and for a 60-bed farm colony dormitory for boys who are being trained to do farm work.

Dr. Harry A. Schneider was superintendent from 1935 to 1942. Dr. H. C. Dunstone was acting medical superintendent from 1942 to 1943. Dr. H. A. Sears was the medical superintendent from 1943 to 1944 when Dr. E. J. Rennell entered upon those responsibilities. The present patient population is 1747.

Mount Pleasant State Home and Training School (1937).—Prominent in the present program of this institution is construction to provide 250 nursery beds for infant defectives—"crib cases." This provision will partially fill an urgent need. This Home and Training School now has a bed capacity of 380, exclusive of the nursery beds mentioned. On December 1, 1949, Dr. Fred W. Palmer became medical superintendent and succeeded Mr. Bradley T. Fowlkes in the responsibilities of management.

St. Joseph's Retreat, Dearborn (1860).—This Retreat, under the auspices of the Daughters of Charity of St. Vincent de Paul, removed from Detroit to its present location in Dearborn in 1881, and into its present spacious buildings in 1886. It is the first and oldest hospital for mental patients in Michigan. A complete reorganization was made in 1945, and now approved for residency in psychiatry it grants all the facilities and opportunities which such approval implies. In making its improvements, it has reduced its bed capacity from 362 to 325. In 1943, Sister Augustine succeeded Sister Kerwin as Sister Superior. In 1945, Dr. Martin H. Hoffman succeeded Dr. Russell T. Costello as medical superintendent.

Mercywood Neuropsychiatric Hospital (1922).—Improvements have permitted this hospital to increase its bed capacity from 40 to 50. Since the death of Dr. Theophil Klingmann, September 1948, patients have been received and cared for largely by their referring physicians, supplemented by the supervision of staff psychiatrists, Dr. Leonard E. Himler and Dr. Harold W. Riggs. Sister Mary Visitation succeeded Sister

Mary Emanuel in 1943. Sister Bertille became administrator in 1945.

Institute for Mental Hygiene of the Battle Creek Sanitarium.—The Battle Creek Sanitarium in its entirety was taken over by the Federal Government August 1, 1942. It was renamed the Percy L. Jones General Hospital and served the Army as such. It is recently rumored that it is to be disposed of to the Veterans Administration or to the state.

Pine Rest Sanitarium at Cutlerville has enlarged and improved its facilities. Dr. Jacob D. Mulder continues as medical superintendent.

The Haven Sanitarium (1932).—Located on 75 acres 25 miles north of Detroit at Rochester, Michigan, it serves as a private hospital (43 beds) for patients carefully selected for intensive psychotherapy and psychoanalysis, supplemented as occasion demands by electroshock and insulin. Physicians, residents, 20 nurses and attendants and 3 occupational-recreational therapists assist the staff of part time private physicians in their therapies, care, and management. Mr. Graham Shinnick continues as manager.

Veterans Administration.—The Detroit Regional Office is located at 310 East Jefferson. Since 1946 the Administration has developed at the same address a very active mental hygiene clinic in charge of Dr. Joseph Slusky. Three hospital centers are located in the state: Michigan Veterans Facility Hospital (1886) at Grand Rapids has both hospital and domiciliary units, 275 beds, Dr. J. J. A. McMullin, medical director; Veterans Administration Hospital (1924), Fort Custer, 2044 beds, Dr. Roger P. Hentz, manager, Dr. Isham Kimball, clinical director; Veterans Administration Hospital (1939), Dearborn, 1118 beds, of which 108 are for psychiatric patients, Dr. Thomas P. Crane, superintendent, Dr. Joseph L. Kubanek, chief of psychiatric service.

Michigan Department of Mental Health, Lansing.—In 1937 the State Hospital Commission of 1921 was reorganized to provide for the first time a central mental health organization on the state level. The law provided for a director of state hospitals and necessary assistants. In 1939 the position of director was abolished and there was created in its place the position of executive secretary to the Commission. The next major change came in 1945, when the present Department of Health was established. The law provides for a director who must be either a psychiatrist or an administrator with at least ten years experience in the administration of mental hospitals or mental health programs. It further provides that the administration of the Department shall be divided into three major divisions: a Division of Hospitals, a Division of Mental Hygiene, and a Division of Administration. The head of each division shall be appointed by the director and one may be additionally designated as deputy director. Provided for also is a policy determining commission of five members, appointed by the Governor for overlapping five year terms. Mr. Charles F. Wagg is the director.

The Department of Mental Health gives assistance to child guidance personnel; to adult psychiatric clinics; to the training of professional personnel; to programs of hospital operation, and additional hospital facilities; and the project of family care for mental patients. The Department has created a Division of Mental Health Education and is also active in research. To the 10 child guidance clinics now in operation it hopes shortly to add at least two. The Department has requested funds and is actively promoting the construction of a psychiatric hospital for children. It has outlined an impressive 10 year program of expansion and its over-all budget request for 1950-51 is $48,629,601.

Child Guidance Clinics.—The Children's Fund of Michigan, founded by James Couzens in April of 1929, created the first child guidance clinic in the State of Michigan in September, 1930. In it the combined abilities of psychiatrists, psychologists, and psychiatric social workers were brought to bear upon the problems of emotionally maladjusted children. In due time this venture stimulated emulation throughout the state, and the Mental Health Department of the State of Michigan brought into being under its own direction a series of child guidance clinics located at strategic centers. (The annual reports of the Children's Fund of Michigan are veritable storehouses of per-

tinent information and should be consulted for amplifications.)

On July 1, 1948, an arrangement was consummated with the Mental Health Department whereby it assumed managerial responsibility for the Detroit Children's Center, consolidating it with another child guidance clinic in Wayne County. The Children's Fund acquired a building at 5475 Woodward Avenue to house the consolidated clinic.

The Children's Fund of Michigan also operates the Northern Michigan Children's Clinic in Traverse City under the direction of Miss Hazel Hardacre.

The Michigan Department of Mental Health, Division of Mental Hygiene, under the direction of Dr. Samuel W. Hartwell, assistant to Director Charles F. Wagg, now supervises the following children's centers: (In each instance the doctor named is the director of the clinic—or acting director. Parenthetically, the given date in the address is the opening date.)

Children's Center of Metropolitan Detroit
5475 Woodward Ave. (October 16, 1944)
Detroit 2, Mich.
James M. Cunningham, M. D.

Grand Valley Children's Center
124 Michigan St., N.E. (January 1, 1945)
Grand Rapids 3, Mich.
Anne B. Cronick, M. D.

Lansing Children's Center
220 N. Pine St. (November 14, 1938)
Lansing, Mich.
Samuel W. Hartwell, M. D. (temporary)

West Michigan Children's Center
1071 Pine St. (July 1, 1942)
Muskegon, Mich.
Miss Madeline Half (acting)

Saginaw Valley Children's Center
1501 N. Michigan Ave. (August 1, 1942)
Saginaw, Mich.
Norman Westlund, M. D.

Flint State Child Guidance Center
922 Cedar St. (October 21, 1946)
Flint 3, Mich.
Paul H. Jordan, M. D.

Kalamazoo Children's Center
217 Pratt Bldg. (September 1, 1942)
Kalamazoo, Mich.
E. M. Williamson, M. D.

Upper Peninsula Children's Center
511 W. College (March 6, 1944)
Marquette, Mich.
Mr. Howard Lamb (acting)

Clinton Valley Children's Center
1 Lafayette St. (November 1, 1944)
Pontiac, Mich.
Mr. Robert H. Whiteley (acting)

Huron Valley Children's Center
310 S. Huron St. (September 1, 1944)
Ypsilanti, Mich.
J. N. P. Struthers, M. D.

In Detroit.—The Psychiatric Division of the Receiving Hospital (1915), despite the overcrowding of its beds, is a very important unit in providing for emergency admissions. Dr. John M. Dorsey, on becoming chairman of the department of psychiatry of Wayne University School of Medicine in 1946, promptly utilized this unit in partial answer to teaching opportunities. This was fostered further when Dr. Thomas V. Hoagland was made its clinical director in March, 1947.

The Merrill-Palmer School of Detroit (1920).—Its infant service, prenursery, and nursery schools, children's clubs and summer camp provide student teachers with invaluable training opportunities. A consultation center for parents and school courses in marriage and family life add not only to its popularity, but also to a growing public demand. Dr. Esther McGinnis is the director. In 1949, 247 children were enrolled and 113 students were in training.

The Psychopathic Clinic of the Recorder's Court (1921) has become of increasing importance to the Courts of Detroit and of the state. Dr. Lowell S. Selling resigned March 1, 1945—Dr. Lennaert W. Wiren succeeded him in that same month. In August, 1948, Mr. Allen Canty was appointed executive director. Dr. Albert L. Wallaert is chief psychiatrist and Dr. Dean R. Asselin, assistant psychiatrist.

Division of Neuropsychiatry, Henry Ford Hospital (1923).—The greatest daily battle of this Division, now in its 27th year, is to obtain an adequate number of beds for its inpatient service. It was hoped that 10% of the total number of general hospital beds could be given over to neuropsychiatric patients, but the demands for admission to other divisions of the hospital have been so urgent that barely an average 7% ratio has been acquired. For more than two years a long waiting list, often reaching 50, was kept, but when during 1948-1949, four patients committed suicide while waiting to be

admitted, this plan was abandoned. Patients and their kin are specifically advised against excessive waiting. A most potent idea in the lay mind is the thought of entering a general hospital for the treatment of his "nervous breakdown" and this in the face of constantly increasing and already excessive expense of such privilege. An additional hospital building is in the making. It will provide expansion for out-patients clinics and research opportunities but will add comparatively few beds to those now available. During the calendar year of 1949, 982 in-patients were treated, there were 11,776 out-patient visits, 2564 consultations to patients on other services in the hospital, 1623 written neuropsychiatric reports to physicians and agencies outside the hospital. The Division of Neuropsychiatry is conducted as an open service, without mechanical restraints of any kind, and in immediate juxtaposition to other patients in the hospital. The Division is accredited for residency in neurology and psychiatry and has a senior staff of 4 full-time psychiatrists, 2 neurologists, and 3 psychologists. Thomas J. Heldt is physician-in-charge and senior consultant of the Division.

Early in the summer of 1946, the McGregor Fund in Detroit gave to Wayne University College of Medicine a grant for an enlarged Department of Psychiatry to be presided over by a full-time professor. Dr. John M. Dorsey, director of the child guidance division of the Children's Fund of Michigan, was chosen by the University to occupy that chair. Three years later that department of psychiary received a United States Public Health Service grant which made it possible to secure the services of Dr. H. Harrison Sadler to assist in the teaching of undergraduate psychiatry.

Recognizing the major function which schools and teachers may perform in the mental health area, a committee of thirty leading educators in the Detroit metropolitan area met during the spring of 1947 at the call of Dr. John M. Dorsey, of the Wayne University department of psychiatry, and Dr. Paul T. Rankin, Assistant Superintendent of Schools of Detroit. The committee drafted plans for a mental health course sponsored by Wayne University and the University of Michigan. Drs. Dorsey and Rankin succeeded not only in securing financial subsidy from local foundations, but also in making the arrangements necessary to muster a wide range of community resources. This mental health program continues to give inestimable help and understanding to teachers and to pupils. Among its cogent effects is the organizing of a Visiting Teachers Association which already has enrolled 100 in its membership.

Michigan is engaged in a six months study to determine what can be done to salvage the lives of sex deviates. Preventive education, reorientation, and early recognition are evident avenues of approach. A state psychiatric clinic devoted to this investigative work was established in January, 1950, under the direction of Mr. Charles F. Wagg, Director of the Michigan Department of Mental Health.

McGregor Center (1940), a hospital for rehabilitation and health education (33 beds), has been the site of research work for the Wayne University College of Medicine department of psychiatry. This hospital unit receives patients representing a cross section of the general practice of medicine. The investigation is concerned with accumulating data on the significance of psychiatry in all kinds of medical practice. The McGregor Center is also used for the purpose of teaching medical students. Dr. John M. Dorsey is the medical director.

The Michigan Society of Neurology and Psychiatry (1908).—As a Society and through its individual members, this group of neuropsychiatrists did outstanding service during the war and in the reconversion period following it. It now boasts a membership of 150. Its current president is Dr. Harry E. August.

The Michigan Society of Mental Hygiene (1936) is doing yeoman work in mobilizing professional and lay support for state and local mental hygiene programs. The president is Edward L. Baker; the executive director Harold G. Webster.

The Cornelian Corner of Detroit (1942) is an organization made up of a mixed group, composed of psychiatrists, obstetricians, pediatricians, physicians, surgeons, psychiatric social workers, nurses, school teachers, and lay people. The primary purpose is the study

and the promotion of parent-child relationships. In its educational programs, it is affiliated with the Michigan Mental Hygiene Society, the Michigan Society of Neurology and Psychiatry, and the Merrill-Palmer School. In its advancements it enlists many prominent national lecturers. Its incumbent president is Dr. Harry Jurow.

The Detroit Psychoanalytic Society was organized in 1940 as a constituent society of the American Psychoanalytic Association. Dr. Richard F. Sterba is its current president.

The Detroit Psychoanalytic Institute was founded in 1945. It is the training and teaching unit of the Detroit Psychoanalytic Society. Its chairman is Dr. Richard F. Sterba. Its training analysts are: Dr. Leo H. Bartemeier, Dr. Richard F. Sterba, Dr. Editha Sterba, of Detroit; and Dr. Maurits Katan and Dr. Anna Katan of Cleveland.

The Michigan State Medical Society added a Section on Nervous and Mental Diseases to its organization in 1947, and its mental hygiene committee is prominent in al matters of neuropsychiatric import. Currently, it is very active in studies of the "criminal sexual psychopath" in cooperation with the Governor's Committee and several other socially, medically, and legally constituted committees. The Michigan State Medical Society, also through its mental hygiene committee, is establishing a mental hygiene committee in each of its constituent county medical societies.

In a terse review of the forward steps taken in neuropsychiatry by Michigan during the past seven years the following command attention: [2]

Outstanding is the progressive improvement in the general care of the mentally ill in its state and county hospitals and its prisons and correctional institutions; the persistent efforts of medicine and of law to have their increasing agreements in behalf of the mentally ill more favorably reflected in legislation; more liberal fostering by the state of child guidance clinics and facilities for war veterans; and the improved provision for the undergraduate and postgraduate teaching of medical students, physicians, and auxiliary personnel.

In Michigan, as elsewhere in the United States, in Canada, and in the world generally, there is still too much political misinterpretation, distrust, and failure of mutual regard in providing for human welfare in terms of the medical, the spiritual, and the common humanities. Too frequently the *demanded wants* of individuals and nations far exceed *actual needs.* For the mentally ill the old bogy of segregation remains too securely intrenched, albeit at times only behind the ramparts of the excessive costs of medical care. The 150 millions of people in the United States annually spend 8.8 billions of dollars for beverage alcohol but not more than one billion for the social care of the miseries incident to such use. Sixty dollars per person, man, woman, and child, for drinkable alcohol, but only $20 per capita annually for education and only 4½% of the average worker's wages goes to pay the costs of medical care. Education and medical care are basic needs. Beverage alcohol is a highly vaunted want. The aspirations and the frustrations besetting both are potently related to the ever increasing demands upon neuropsychiatry.

The ninety-ninth annual meeting of The American Psychiatric Association was held in Detroit in 1943. Seven years later it is again the privilege of the neuropsychiatrists of Michigan to extend to the medical profession and The American Psychiatric Association on the occasion of its one hundred-sixth annual meeting, a most hearty welcome.

The author is indebted to Dr. John M. Dorsey, Dr. Raymond W. Waggoner, and the several state hospital superintendents for assistance in collecting the data for this review.

[2] The epitome for the century 1843 to 1943 (Am. J. Psychiat., 99: 731) should be consulted, for the advancements have been assiduously maintained.

PROCEEDINGS OF THE AMERICAN PSYCHIATRIC ASSOCIATION

THE ONE HUNDRED AND FIFTH ANNUAL MEETING—MONTREAL, 1949

The annual meeting was held at the Windsor Hotel, Montreal, Quebec, May 23-27, 1949. The meeting was called to order by the President, William C. Menninger, who read a letter from the Honorable C. D. Howe, Acting Prime Minister of Canada, and a telegram from Dr. Oswaldo Camargo Abib, of Brazil.

Dr. Menninger then presented Professor Albert Lesage, representing the Hon. J. P. A. Paquette, Minister of Health of the Province of Quebec, who greeted the assembled members and guests. He then introduced the President-Elect, Dr. George S. Stevenson, and called on the Medical Director for a report of his first year of work.

The Secretary, Dr. Leo H. Bartemeier, announced that the membership of the Association had increased by 343 during the past year and was as of April 1, 1949, 4,678, including 23 Honorary Members, 25 Corresponding Members, 108 Life Members, 986 Fellows, 3,164 Members and 372 Associate Members. The Treasurer, Dr. Howard W. Potter, gave his report, which will appear in another section of these proceedings. Afterwards, Dr. William C. Menninger gave the Presidential Address. The President-Elect, Dr. George S. Stevenson, responded to the message of the President.

The Secretary read the names of members deceased during the year. There followed memorials to deceased Presidents of the Association, given by Dr. Earl D. Bond for Dr. Samuel T. Orton, President 1928-29; by Dr. Samuel W. Hamilton for Dr. C. Fred Williams, President 1934-35; Dr. Winfred Overholser for Dr. Ross McC. Chapman, President 1937-38; Dr. Karl Menninger for Dr. James K. Hall, President 1941-42.

Dr. Pierre Pichot of Paris, a guest of the American Psychiatric Association, gave some details of the first International Congress on Psychiatry, to be held in Paris in September 1950. He announced that the conference would be divided into seven sections on general psychopathology, clinical psychiatry, neurophysiology and anatomy, biological treatment, psychotherapy and psychosomatics, social psychiatry and child psychiatry.

At the general session for members of the Association, on May 24, the following Fellows were nominated for office: President-Elect, Dr. John C. Whitehorn and Dr. James H. Wall; Secretary, Dr. Leo H. Bartemeier and Dr. Lawson G. Lowrey; Treasurer, Dr. Howard W. Potter and Dr. Newdigate M. Owensby; Auditor, Dr. Coyt Ham; Councillors, Dr. Lauren H. Smith, Dr. Mesrop A. Tarumianz, Dr. Francis J. Braceland, Dr. Nathan Rickles, Dr. Esther L. Richards, and Dr. Thomas K. Davis. The President selected as tellers the presidents of the affiliated societies or their designates.

Dr. Arthur P. Noyes spoke for the Reorganization Committee, reporting the history of their efforts since 1945 and the action of the Council in November, 1948, that the reorganization plan, as it was finally worked out, should not at this time be carried out. A motion to this effect was made by Dr. Spafford Ackerly: "In order to clear the air and remove all doubt and confirm the action of the Council last November, I move that this Body reject the reorganization plan presented to this Association last May, in Washington, in 1948." The motion was seconded by Dr. Abram E. Bennett and Dr. Robert McGraw and was unanimously carried. Dr. Noyes then proceeded to read certain proposed amendments to the Constitution and By-Laws which the Committee on Reorganization wished to submit to the Association. Amendments proposed by the New York Society of Clinical Psychiatry were presented by Dr. Oskar Diethelm. Comments on the suggestions for amending the Constitution were made by various affiliated societies and by the Committee for the Preservation of Medical Standards in Psychiatry.

The Association again met in business ses-

sion May 25 at 9:15 a.m. and heard the report of the tellers, presented by the Chairman, Dr. Lloyd Thompson. Those receiving the highest votes and elected by the Association were Dr. John C. Whitehorn, President-Elect; Dr. Leo H. Bartemeier, Secretary; Dr. Howard W. Potter, Treasurer; Dr. Coyt Ham, Auditor; and Drs. Francis J. Braceland, Lauren H. Smith, Mesrop A. Tarumianz, Councillors. The retiring President, Dr. William C. Menninger, also became a member of Council. On motion by Dr. Walter Freeman, seconded by Dr. George H. Stevenson, the membership voted without dissent to elect as Associate Members, Members, and Fellows the names on the list submitted by the Membership Committee.

The Secretary reported actions of the Council at its meetings in November, 1948, and on May 21 and 22, 1949.

Following the business session Wednesday morning, the Association enjoyed hearing Dr. Howard Hanson, Dean of Eastman Conservatory of Music, Rochester University, illustrate at the piano "The Affective Power of Consonance and Dissonance in Music." This was not the first time Dr. Hanson had appeared at an APA annual meeting, and his presentation was again a pleasing and informative addition to the program.

The annual dinner was held the evening of May 25 in the Windsor Hotel ballroom, with the President, Dr. William C. Menninger, presiding. Fellowship Certificates were presented by the President to those elected to Fellowship in 1948. The first Lester N. Hofheimer Award was presented to Dr. Benjamin Pasamanick of the Children's Service at Kings County Hospital, Brooklyn, N. Y., for his research: "Comparative Study of the Behavioral Development of Negro Infants." The Mental Hospital Achievement Award was divided between Columbus State Hospital, Columbus, Ohio (Dr. J. F. Bateman, superintendent) "For Creating a New Method of Evaluating and Improving the Attendant and Patient Relationships"; to Boston State Hospital, Boston, Mass. (Dr. Walter E. Barton, superintendent) "For Improving Professional Services in the Hospital by the Utilization of Part-time Professional Men and Women of the Community"; and to Veterans Administration Hospital, North Little Rock, Arkansas (Dr. Harold W. Sterling, manager) "For Improving Public Relations." Professor David Thomson, M. A., Ph. D., F. R. S. C., of McGill University spoke to the members on "Caries in the 'Ivory Tower.'" This intellectual and humorous essay on science and scientists of the day, emphasizing psychiatrists, was one of the highlights of the meeting. Following the dinner, entertainment was provided by the Alouettes' Vocal Quartet, interpreters of world famous French-Canadian folksongs, after which there was dancing for the members, their wives, and guests.

Another feature during the annual meeting was the Devereux Foundation luncheon on Wednesday, May 25. The moderator was Dr. Emile Legrand, of Montreal. The speaker was Dr. William B. Terhune, of the Silver Hill Foundation, New Canaan, Conn., who spoke on the topic "Physiological Psychiatry." His paper was discussed by Dr. Cullen W. Irish of Los Angeles, and Dr. Hans Selye of Montreal.

Among the many pleasant events of the annual meeting were the entertainment activities of the Ladies' Committee. A large number of the ladies were guests of the Committee for the Laurentian Mountain Bus Trip, a tour of 50 miles through regions covered with lakes and rivers in mountainous settings.

On Thursday evening, May 26, a civic reception was given at Mount Royal Chalet by His Honor, Camillien Houde, Mayor of Montreal. This was a delightful occasion and attended by more than a thousand of the convention members, as guests of the city administration. The view from the Chalet over the city and the St. Lawrence River was a fitting climax to the delightful entertainment afforded by Mayor Houde and his Committee.

Another important event was a public meeting for the citizens of Montreal sponsored by the American Psychiatric Association on the evening of May 26, in the Ballroom of the Windsor Hotel. To the assembled guests, who overflowed into surrounding rooms where microphones were made available, Dr. Henri Hacaen, of the

Paul Brousse Hospital, Paris, France, delivered an address on "Biological-Psychosocial Reactions of the Mental Patient during the War and Occupation in France," and President Menninger spoke on the subject "Psychiatry in Everyday Life."

The final business session was held on May 27, at 9:20 a.m. The Secretary reported the further actions of the Council. The assembly accepted the report of the Resolutions Committee (Dr. Benjamin H. Balser, chairman), which expressed thanks to Mayor Camillien Houde of Montreal; Dr. J. P. A. Paquette, Minister of Health of the Province of Quebec; and to the Honorable Mark Trudel, Minister of State and President of the College of Physicians and Surgeons for Quebec. It was also resolved, "That the American Psychiatric Association be complimented upon the outstanding success of this 105th annual meeting, held in Montreal, Quebec, Canada, and its members be congratulated for attending in such large numbers and displaying such interest," and a number of resolutions congratulating the officers of the Association were offered; the chairmen and members of committees and affiliated societies for their work throughout the year; the Program Committee; Dr. T. E. Dancey and the members of the Committee on Arrangements; expressing gratitude to Mrs. A. E. Moll, chairman, and her Committee on Women's Arrangements; to the Medical Director and Executive Assistant; Dr. Clarence B. Farrar, Editor of the American Journal of Psychiatry; to guest speakers Dr. Henri Hacaen of Paris, France, Professor David Thomson of McGill University, and Dr. Howard Hanson of the University of Rochester, New York; and to the Press for its accurate reporting.

The membership heard Dr. Robert Felix give a brief report and explanation of the new budget (outlines in detail later in this report). Dr. Felix, chairman, reported that the Finance Committee consisting of Drs. Winfred Overholser, Clarence H. Bellinger, Frederick W. Parsons, Jack R. Ewalt, and Howard W. Potter, ex-officio, presented the budget which had been approved by the Council, and made the following comments: Total receipts from membership dues and minor sources of income—$107,125; estimated income from the Office of the Medical Director—$13,250; from the JOURNAL—$38,400—a total of $158,775. To be expended in the Medical Director's Office—$51,490 ($13,250 to be returned from income from that office); in the New York Office and for the Biographical Directory—$42,577 (the Budget Committee recommended that the preparation of the Biographical Directory go forward, even though some loss was anticipated, as it was felt that it was better to publish the Directory with the loss rather than to take the loss and have no directory, the loss in each case being about the same). To be expended for the JOURNAL $62,830.51 with an estimated income of $65,861.51. The income, however, is affected by a bill of $12,000 overdue from last year and some other monies for which Council has authorized payment, and which must be charged against this year's budget even though the bills were incurred last year.

Dr. Felix reported that after 5 days of conferring with Committee Chairmen and some of the retiring and incoming chairmen, the Budget Committee found for the coming year an operating deficit of $17,743, expected a smaller deficit income the coming year, but no deficit following that year.

The President called on Dr. Henry A. Davidson, chairman of the Committee on Constitution and By-Laws, to comment on the suggestions made at the earlier meeting of the members on the proposed amendments submitted by the Committee on Reorganization. He reported that changes had been made which were in line with the suggestions of the majority of the members at the previous meeting. The concensus of the meeting was that if the proposed amendments could be printed in the JOURNAL or distributed in the Mail Pouch within the next three months, it would not be necessary to consider all details at this meeting.

The incoming President, Dr. George S. Stevenson, was called upon and stated in part, "When you think these two years have added a thousand to our membership, when you think of the leadership we have had in the American Psychiatric Association, when you think of the efforts during this period to increase the length of our trousers to the point commensurate with that development

and some growing pains along with that period, it really marks a milestone in the growth of the American Psychiatric Association. . . ." The President-Elect, Dr. John C. Whitehorn, was presented to the membership and expressed his appreciation of the honor conferred upon him in his election to the highest office which the Association had to confer. He made a plea that the annual meetings should provide an opportunity for a discussion of the live issues of the day, both as to psychiatry in general and as to the important points of view that exist and will always exist in a large organization. This final business meeting was adjourned by President Menninger at 9:50 a.m.

The 105th annual meeting of the Association adjourned at 5:00 p.m., May 27, 1949.

LIST OF DECEASED MEMBERS AS READ AT THE 1949 ANNUAL MEETING

Herman M. Turk, New York, N. Y. ..... Died Jan. 23, 1945
John C. McCall, Ogeechee, Ga ..... Died Jan. 29, 1945
Albert Slutsky, Los Angeles, Cal ..... Died Nov. 19, 1946
Roy A. Thornley, Washington, D. C. ..... Died Dec. 30, 1946
William E. Gardner, Louisville, Ky. ..... Died April 8, 1947
William J. Donahue, Orange, N. J. ..... Died April 18, 1947
P. G. Borden, Buffalo, N. Y. ..... Died July 4, 1947
Lewis J. Smith, Brooklyn, N. Y. ..... Died Aug. 16, 1947
Benjamin F. Smith, Jackson, Fla. ..... Died Aug. 17, 1947
Henry A. Hutchinson, Dixmount, Pa. ..... Died Oct. 5, 1947
Ira F. Peak, Greenville, Tex. ..... Died Dec. 23, 1947
George I. Yearick, Pittsburgh, Pa. ..... Died Dec. 29, 1947
Russell C. Novak, Ponoka, Alb., Canada ..... Died Jan. 21, 1948
Harvie De J. Coghill, Richmond, Va. ..... Died Feb. 6, 1948
Simon Sieger, Bay Pines, Fla. ..... Died Feb. 21, 1948
A. A. Brill, New York, N. Y. ..... Died Mar. 2, 1948
Edwin John Doty, New York, N. Y. ..... Died Mar. 19, 1948
Thomas M. Barrett, Emsworth, Pa. ..... Died Mar. 27, 1948
Clifford W. Mack, Livermore, Cal. ..... Died Mar. 31, 1948
Horace V. Pike, Danville, Pa. ..... Died Mar. 31, 1948
Murray N. Fowler, Mansfield, Ohio ..... Died Apr. 29, 1948
R. Montfort Schley, Buffalo, N. Y. ..... Died May 5, 1948
George W. Mills, Brooklyn, N. Y. ..... Died May 8, 1948
G. Ritter Smith, Sedro-Wooley, Wash. ..... Died May 15, 1948
Ermin L. Roy, Lyons, N. J. ..... Died May 21, 1948
David B. Rotman, Chicago, Ill. ..... Died May 30, 1948
George H. Torney, Jr., Brookline, Mass. ..... Died June 1, 1948
C. Fred Williams, Columbia, S. C. ..... Died June 3, 1948
Henry A. Cotton, Jr., Trenton, N. J. ..... Died June 20, 1948
Howard Rouse, Lewiston, Idaho ..... Died June 24, 1948
Cyril Barnert, Westbury, N. Y. ..... Died July 27, 1948
John S. Richards, Central Valley, N. Y. ..... Died Aug. 1, 1948
Hanford Waterfield, New York, N. Y. ..... Died Aug. 18, 1948
Persis F. Elfeld, Wilmington, Del. ..... Died Aug. 26, 1948
Frank E. Jones, Knoxville, Tenn. ..... Died Sept. 2, 1948
Abraham Myerson, Boston, Mass. ..... Died Sept. 3, 1948
Benjamin P. Bell, Oklahoma City, Okla. ..... Died Sept. 5, 1948
James K. Hall, Richmond, Va. ..... Died Sept. 11, 1948
Theophil Klingmann, Ann Arbor, Mich. ..... Died Sept. 19, 1948
Ross McC. Chapman, Towson, Md. ..... Died Sept. 24, 1948
Milton P. Hill, Baltimore, Md. ..... Died Oct. 9, 1948
Warren G. Murray, Dixon, Ill. ..... Died Oct. 13, 1948
Eva H. Engel, New York, N. Y. ..... Died Oct. 20, 1948
Louisa E. Boutelle, Provo, Utah ..... Died Nov. 3, 1948
Earl K. Holt, Harding, Mass. ..... Died Nov. 10, 1948
Samuel T. Orton, New York, N. Y. ..... Died Nov. 17, 1948
George G. Armstrong, Portsmouth, Va. ..... Died Nov. 22, 1948
N. Emmons Paine, Walpole, Mass. ..... Died Nov. 30, 1948
Karl Bonhoeffer, Berlin-Charlottenburg, Germany ..... Died Dec. 4, 1948
Louis J. Saxe, Phoenix, Ariz. ..... Died Dec. 13, 1948
Harry S. Sullivan, Bethesda, Md. ..... Died Jan. 1, 1949
Eugene M. Wiedenmann, Topeka, Kans. ..... Died Jan. 29, 1949
Harold S. Hulbert, Chicago, Ill. ..... Died Feb. 14, 1949
Henry A. Hewins, Oakley, Cal. ..... Died Feb. 23, 1949

MEMORIALS TO PAST PRESIDENTS

SAMUEL TORREY ORTON, M. D.

1879–1948

Dr. Samuel Torrey Orton, President of The American Psychiatric Association in 1928-29, died on November 18, 1948 at the age of 69, from complications following a broken hip sustained in a fall at his country home 6 weeks earlier. Although he had been planning to retire and spend the winter in California, he had continued his private practice until a few days before his accident.

The scientific spirit was nurtured in Samuel Orton from boyhood by his intimate association with his eminent father, Dr. Edward Orton, the first president of Ohio State University and a distinguished geologist. He prepared for college under his cousin, Mr. Horace Taft, at Watertown, Connecticut, received an A. B. from Ohio State University, an M. D. from the University of Pennsylvania, and an M. A. from Harvard. In Boston he came under the influence of Dr. Frank B. Mallory in pathology and Dr. Ernest Southard in neuropathology. His first position was that of pathologist to the Columbus State Hospital, and his second was pathologist to St. Ann's Hospital and Public Health Officer for Anaconda, Montana. This led to over 3 years of service at the Worcester State Hospital where he developed technical methods of brain study and became clinical director. Appointment then came as scientific director to the Department for Nervous and Mental Disease of the Pennsylvania Hospital, in preparation for which he spent six months with Alzheimer in Breslau. From 1919 to 1927 he was professor of psychiatry at the University of Iowa: there he directed the new psychiatric hospital and organized mental hygiene clinics for children with a mobile unit to serve the rural areas. Here he became interested in the reading and writing disabilities of children and henceforth made this his major interest; his Salmon Memorial Lectures in 1936 were on this subject. In 1927 he came to New York for the rest of his life and became professor of neurology and neuropathology at the College of Physicians and Surgeons until 1936. From this year on he devoted himself to practice in his favorite field of language disabilities, working under the handicap of peptic ulcers.

In 1929 he was President of the American Psychiatric Association and in 1932 President of the Association for Research in Nervous and Mental Disease. In 1945 the University of Pennsylvania gave him the honorary degree of Doctor of Science.

He is survived by a son and two daughters —one a physician—and his wife, who was also his professional partner.

EARL D. BOND, M. D.

CHARLES FRED WILLIAMS, M. D.

1875–1948

Dr. Charles Fred Williams, held in affectionate esteem throughout the Association as "C.F.," was born August 6, 1875 in York County, South Carolina, and died at "Cherry Hill" near Columbia on June 3, 1948. He was president of this Association in 1934-35.

Dr. Williams' early education was obtained by tutoring and in the public schools. From boyhood he wished to be a physician and in 1899 he received a medical degree at the University of Maryland. He practiced in his native York County for a time, then became an acting assistant surgeon in the United States Army, with which he served 2 years, from 1901 to 1903. The second year was spent in the Philippines.

Leaving the Army in March 1903 he took a refresher course at the University of Maryland, married, and settled in Columbia. An army that had learned from bitter experience the sanitary lessons of the Spanish War was likely to inspire any young physician with enthusiasm for public health procedures. It was therefore logical for Dr. Williams to become city physician of Columbia in 1904, secretary of the State Board of Health in

1907, and in 1908 the first state health officer. Here was an opportunity to demonstrate his ability in medical organization. His work won recognition outside as well as inside his state, and in 1910 he was vice-chairman of the Section on Preventive Medicine of the American Medical Association. That year he relinquished his state post and did some postgraduate work in Europe. He resumed the practice of medicine in Columbia in 1911, but in the same year found time to organize the first tuberculosis clinic in that city.

In 1915 the South Carolina State Hospital was a subject of considerable concern on the part of Governor Manning. Its career had been long and honorable, but interference had occurred and the Governor was seeking competent direction. He appointed Dr. Williams to the Board of Regents that governed the institution and conferred with authorities in our field, particularly the medical director of the National Committee for Mental Hygiene, about the next step. Presently the Governor called on Dr. Williams to take the vacant superintendency, and overruled his reluctance to giving up his private practice. On May 1, 1915 he became superintendent of the South Carolina State Hospital, where he remained for 30 years. He made the proviso that Dr. Salmon should help him find an assistant who would bring the clinical work of the institution to the best standards of the time. This was done, and the warm friendship that promptly developed and continued between Dr. Williams and his clinical director, Dr. Sandy, displayed the fine character and professional attitude of both men.

His personal characteristics impressed themselves not only on his immediate associates but on persons whom he met in other relations and particularly on the membership of this Association. He was of good height, and erect. He had a keen conscience, a good sense of humor, a fund of original observation, and a persuasive way of stating his opinions. He loved to fish and hunt. He was patient under criticism but cogent in stating a fact and his opinion about it. Early in his career he was attacked for neglect of a patient. The record showed that the patient had left the hospital before he became superintendent. His reply to the unwarranted attack did not stop at that point but went on to show that the patient had been very well treated by his predecessor and his argument was so conclusive that the accusation was publicly withdrawn. He protected his employees from political meddling so effectively that such efforts soon vanished.

Needless to say, the institution was considerably enlarged during the 3 decades of Dr. Williams' superintendency. A second site had been taken 7 miles from the original and Dr. Williams made an extensive development of the branch of the hospital at that place. The list of improvements covers all the fields that might be expected in a growing institution.

Dr. Williams was interested in research. He formed an alliance with the U. S. Public Health Service, which carried on its studies of malaria and distributed its therapeutic malarial material from the grounds of the hospital. Dr. Williams planned and ultimately effected the establishment of the Ensor Research Foundation and housed it in a suitable new building on the hospital grounds. Here all necessary laboratory procedures could be carried out in proximity to wards where patients might be studied. He persistently gathered resources for this psychiatric Foundation until over $135,000 has become available. After retirement from the superintendency he held the position of director of research to the end of his life.

In 1903 he married Miss May Wilson, who passed away in 1930. Three daughters survive: Mrs. Preston C. Manning, Mrs. William C. Coker, and Miss Adeline Hughes Williams.

Many responsibilities were laid on Dr. Williams by medical and welfare organizations, his service group, and his church. He was at different times president of the State Medical Association, of the State Hospital Association, of the State Society for Mental Hygiene, the Community Chest. From 1923 he was professor of psychiatry in the Medical College, State of South Carolina. He was given by the University of South Carolina the Algernon Sidney Sullivan Award for unselfish service; this he considered his greatest honor. The state American Legion awarded him a plaque for distinguished ser-

vice and the University of South Carolina conferred on him the honorary degree of doctor of laws.

In this Association Dr. Williams will long be remembered for the same characteristics that endeared him to his neighbors. His unselfish helpfulness, his good judgment of what needed to be done and how to do it, and his appreciative persuasiveness in dealing with those who could not at first see the logic of his position made his presidency a happy period in our history.

SAMUEL W. HAMILTON, M. D.

ROSS McCLURE CHAPMAN, M. D.

1881–1948

Dr. Ross McClure Chapman, President of the American Psychiatric Association during the year 1937-1938, died in Baltimore, Maryland, September 24, 1948, after a long illness. He was born in Belleville, New York, July 13, 1881, the son of Dr. Eugene A. Chapman and Agnes McClure Chapman. He was graduated from the University of Michigan Medical School in 1905, and after a year of general practice joined the staff of the Utica State Hospital, transferring to Binghamton in 1907. There he was closely associated with such men as Wagner, May, Kirby, and Tiffany. White had only recently left Binghamton to go to Washington; Meyer, August Hoch, Jelliffe, Brill, and Salmon were other leaders with whom he came in contact then—a stimulating group indeed. In 1916 Dr. Chapman joined the staff of Dr. White at Saint Elizabeths Hospital as clinical director, soon becoming first assistant physician. After service abroad during World War I as major in the Medical Corps of the Army he returned to Saint Elizabeths, but shortly thereafter, in 1920, he left to assume the superintendency of the Sheppard and Enoch Pratt Hospital. This position he occupied with distinction until his death.

As superintendent, he followed the principle of making the hospital a place where everything possible might be done for the patient which could be helpful to him; an early student of Freud's important contributions, he utilized them; he developed occupational therapy and psychiatric nursing to a high level; and as new physical methods of treatment were devised, he employed them as well. He believed, as he put it in his Presidential Address: "the heart of psychiatry, its *vis a tergo,* must be hospital psychiatry. . . . Without sound hospital administration, clinical study and research cannot prosper." We all remember with gratitude the early recognition that he gave to Dr. Harry Stack Sullivan, and his continuing support of the William Alanson White Psychiatric Foundation and the Washington School of Psychiatry. These are but examples of his breadth and foresight.

Dr. Chapman was interested in psychiatric teaching, and served as professor of psychiatry at the University of Maryland Medical School from 1923 on. He was a charter member of the American Psychoanalytic Association, and was President of the American Psychopathological Association in 1928. One of his many services to the American Psychiatric Association was his sponsorship of the Biographical Directory, published in 1941. This project was one of the recommendations in his Presidential Address in 1938. His other recommendations, read in the light of subsequent events, sound strangely prophetic, and illustrate forcefully the true wisdom which he possessed.

In 1908 he married Marion E. Clapp, who survives him.

Ross Chapman was far more than an outstanding clinician, hospital administrator, and psychiatric statesman, however. He had a capacity for true friendship that is all too rare. He was warm, sympathetic, and loyal, and his many friends have experienced a deep sense of loss in his passing. The Association extends its deepest sympathy to his widow.

WINFRED OVERHOLSER, M. D.

JAMES KING HALL, M. D.

1875–1948

In James King Hall, on September 10, 1948, this Association lost a most beloved ex-President. All of us who shared the steady warmth and deep loyalty of his friendship know how unstintingly he gave of himself. He was never ashamed of showing his overflowing capacity for giving love.

Many of us here today, when we think of J. K. Hall, will think first of the many precious little things, tokens of his affection and thoughtfulness, which in the final count attest the bottomlessness of the heart that conceived them. We remember the warm hospitality that characterized visits with Dr. and Mrs. Hall at their home in Richmond, and the joy he took in showing the historic sites about the city, vividly conjuring the past before our eyes in the light of his really great knowledge of the history of the South. We remember the many warm, personal letters in which his sensitive scholarship was blended with gentle, wise humor. We remember the gifts that arrived from time to time—books, the seeds of a tree to plant on one's lawn, a crate of sweet potatoes grown at the Westbrook farm, or beautiful flowers which he himself picked from the gardens of Westbrook Sanatorium.

He was a grand and gracious gentleman of the old school, was J. K. Hall. He seemed to extend the Southern tradition of hospitality to embrace all his colleagues of this Association in a sort of gracious, genial, affectionate neighborliness. This amazing capacity of his to maintain so many friendships on a highly personal level greatly endeared him to his colleagues, but it was also probably at the core of his success as a doctor and psychiatrist.

One of his lifelong friends, Dr. Wm. MacNider, former dean of the Medical School of the University of North Carolina, wrote of him:

"There was no commencing or ending to his day of toil for others. Sundays were not spent at ease at church or at home with the charm of his family. Such Sabbath days of rest more than likely found him in some jail or other penal institution in which he searched the inmates for a physical basis for their mental aberrations as crime, and not infrequently he was successful. Or perhaps he spent hours upon hours with a father or a mother distraught with sorrow over a mental situation in their family. He gave and gave until the end. The greatest contributions of this man to human suffering are unknown and unknowable. They may be found in the deep and inner life of innumerable human beings far removed from any organized medical assistance who came to him as father-confessor and mental adjustor to be rerelated to life as they had to live it."

James King Hall was born on his family's plantation near Statesville, North Carolina, September 28, 1875. His father was a general practitioner, and James and his 5 brothers and sisters were reared according to the rigorous scholastic tradition of their Scotch-Irish forebears who were doctors, preachers, and teachers. He graduated from the University of North Carolina *magna cum laude* in 1901. There, he was awarded membership in Phi Beta Kappa, and completed his first year in the Medical School during his senior year as an undergraduate. After a fifth year at the University as a second-year medical student, he transferred to Jefferson Medical College in Philadelphia, where he received his medical degree in 1904. It was during his interneship at the Polyclinic Hospital and College for Graduates in Medicine, in Philadelphia, that Dr. Hall first became interested in neurology and psychiatry. Under the guidance and inspiration of Dr. William G. Spiller, who was director of the neurological clinic of the Polyclinic Hospital, and Dr. F. X. Dercum, one of the pioneer neuropsychiatrists of the city, the young student was early imbued with the high respect for scientific integrity which was so deeply imbedded in his subsequent life.

Dr. Hall's career in psychiatry began with his appointment as assistant physician to the medical staff of North Carolina's state hospital at Morganton. There he availed himself of the opportunities for research that Dr. Patrick L. Murphy, superintendent of the hospital, provided for his young associates, to carry out investigations on pellagra. His felicitous association at Morganton with Dr. Paul V. Anderson and Dr. E. M. Gayle

led to their establishment of the Westbrook Sanatorium in 1911, on land that the three men purchased on the outskirts of Richmond. From that time until his death, Dr. Hall was president of the Westbrook Sanatorium, and under his guidance it became one of the most progressive private psychiatric hospitals in the country.

It was inevitable that a man of Dr. Hall's broad cultural background, fine intelligence, and deep loyalties should find himself a leader among his colleagues. He served as president of the Richmond Academy of Medicine, the Tri-State Medical Association of Virginia and the Carolinas, the Association of Private Psychiatric Hospitals, and the Southern Psychiatric Association. His active leadership in local and state medical societies bears witness to his staunch conviction that psychiatry should be integrated both in its theory and in its practice with the other medical specialties, and that a psychiatrist should be first of all a good doctor. Dr. Hall held active membership in the National Committee for Mental Hygiene, the Virginia and North Carolina Medical Societies, and the American Association for Mental Deficiency, as well as in a number of philanthropic and cultural organizations. In 1935 he was awarded an honorary LL. D. by the University of North Carolina.

Dr. Hall put his heart into serving the American Psychiatric Association. He served on its Council for many years, and when he was elected its president in 1941, he worked more than almost any other president toward making it an active, vigorous organization fulfilling the professional needs of its members. His many personal friendships with its members, his broad vision and cultural background enabled him to accomplish a great deal toward extending and stimulating the activities of our Association during that year. A distinctive feature of his administration was his interest and efforts in broadening the general cultural background of psychiatrists, particularly the younger members of the association.

James Hall's scholarly attributes and his flair for historical research came prominently to the service of our Association in his superb editorship, with Dr. Zilboorg, of *One Hundred Years of American Psychiatry,* published in 1944, the definitive historical document of the development of psychiatry in this country. Through his extensive contributions to the medical literature, Dr. Hall will be remembered as a leading proponent of the cause of mental hygiene and preventive psychiatry in the South. He had love for his country and a feeling for its past, which led him to become one of the foremost authorities on the history of his state of Virginia. He had really an encyclopedic knowledge of the lives of its great men—especially Thomas Jefferson, Patrick Henry, and Robert E. Lee—and of the battles of the War Between the States. Despite his pride in the traditions of the South, there was no trace in him of sectionalism or of bitterness.

His remarkable capacity to give of himself with such abandon to his patients and to his friends was due in no small degree to his wife, Laura Ervin Hall, whose graciousness, charm, and fine intelligence are an inseparable part of our treasured portrait of J. K. Hall. The strength and fineness of both are blended in their three sons, James King, Jr., Dorman Thompson, and Samuel Ervin.

If we should search for one distinctive characteristic as the wellspring of all that James K. Hall means to us, it would probably be the quality of reverence. His reverence for truth, blended with his reverence for tradition and for the past, accounts for his high stature among us as a scientist, progressive and yet well poised among passing fads in treatment and in theory. His reverence for the uniquely individual in men was the heart of his distinguished success in interpersonal relationships, both among his many friends and among his patients. Dr. Hall had, too, a profound reverence for God; he was a good Presbyterian. But above all he was a good man, in every sense of the word, a man who loved greatly and was greatly loved. He demonstrated again that more important than technical proficiency, more important than erudition, and more important than professional skill—all of which J. K. Hall possessed—a good psychiatrist is a man of good will, good character, and good heart, who loves his fellow men.

KARL MENNINGER, M. D.

SUMMARY OF MEETINGS OF COUNCIL AND EXECUTIVE COMMITTEE, JUNE 24, 1948 TO MAY 26, 1949

Executive Committee Meeting, June 24, 1948.— The Committee invited Dr. John D. Griffin, chairman of the Committee on Public Education, to be present at all meetings of the Executive Committee; advised the Secretary to inform all Committee chairmen about informing the Public Education Committee of their activities; approved in principle the recommendation to employ a director of public relations but deferred action for lack of funds. Referred the question of relations of APA to the National League of Nursing Education to the Committee on Psychiatric Nursing. Voted to publish 1,000 copies of the Proceedings of the Association in a supplement to a regular issue of the Journal; these to be available to members on request. Appointed Dr. Daniel Blain as official observer to the coming meeting of the World Health Organization. Decision was made to hold the next Council meeting on November 16, 1948 and simultaneous meetings of all Committees on November 15, 1948 at the Berkeley-Carteret Hotel at Asbury Park, N. J. Requested Drs. Daniel Blain, John D. Griffin, and G. S. Stevenson to serve as *ad hoc* committee to work out a plan for quick mobilization of psychiatric opinion to influence congressional appropriations for the National Mental Health Act. Voted to change the duration of maximum appointment of members of committees from 5 years to 3. Deferred application of Texas Neuropsychiatric Association for additional information. Voted to authorize the Treasurer to pay traveling expenses of the guests of the Association who participated in the panel on psychiatry and religion at the annual meeting. Voted $394.20 to the Committee on Public Education to defray expenses incurred just before the meeting, not to be included in this year's Committee allotment. Approved a recommendation from the Treasurer that Council regard certain committee expenditures from March 11, 1948, to April 15, 1948, as an unanticipated budgetary deficit which would not be made a part of the 1948-1949 allotment. Agreed that the traveling expenses of the chairman of the Committee on Public Education to attend Executive Committee meetings should come from the appropriations of that Committee. Approved in principle the work of the Council for Clinical Training and Pastoral Care. Dr. Daniel Blain and Mr. Austin Davies were requested to make a study of ways and means of overcoming Journal financial deficits and the advisability of publishing a lay magazine. Agreed that the Committee on Medical Education should contact the Council of Medical Education and Hospitals of AMA concerning their plans to resurvey medical schools and training centers. Approved in principle that the annual meeting devote one session (immediately after the meeting) to psychiatric clinics and illustrative teaching methodologies. Approved the suggestion of the Editor of the Journal to bind the Journal, Volume I, Number I, to date, at an estimated cost of $285.00 and referred this matter to the Budget Committee. Approved the arrangements made between the Editor and the Medical Director as to what items should go into the Newsletter and what into the Journal. Recommended that the Committee on Resolutions be made a standing Committee and requested them to describe their function. Discussed how members of Council might participate in the affairs of the Association between meetings. Instructed the Secretary to send minutes of the Executive Committee meetings to all members of Council, inviting their comments and suggestions for future agendas. Approved the President's suggestion of working closely with state medical society committees on mental hygiene. Approved the President's efforts to get each committee to outline its concept of its function and to indicate immediate steps toward proceeding with their activities. Recommended to Council that the Membership Committee be made up of Drs. William H. Dunn, John F. Regan, Lawrence Kolb, and John D. Griffin. Approved the President's effort toward organizing a federation of psychiatric organizations. Considered a long-time program for the psychiatric placement service. Refused official comment on a plan of the American Psychological Association to communicate with psychiatrists concerning test materials. Referred to the Committee on Clinical Psychology the matter of implementing the report of the Joint Committee on Clinical Psychology of the 2 organizations. Approved the employment of Mr. Robert L. Robinson as Chief of the Information Service, in the Medical Director's Office, at an annual salary of $4,500.00. Discussed the matter of $1,500.00 set aside in the Association's Funds for an Isaac Ray Lectureship on legal aspects of psychiatry in collaboration with law schools. Referred this matter to Dr. Gregory Zilboorg, Committee on History of Psychiatry. Voted against the request of the magazine "The Interne" for a grant to assist continuing its publication. Requested the chairman of the Committee on Reorganization to formulate a list of questions and answers for the information of the membership on the reorganization plan. Voted that interim reports of committees should be printed in the Journal as they became available and brief resumes be published in the Newsletter. Voted to solicit opinions from the members of the Association regarding the first Newsletter. Accepted the recommendation of Dr. Daniel Blain that definite planning for the financial future of the Association be undertaken and recommended that the President appoint 3 members of the Council to undertake this task. Voted to reprint the Membership Directory at once and borrow the sum involved in the next year's budget. Accepted with regret the resignation of Dr. Albert W. Pigott. Approved the requests (endorsed by the Treasurer) for $500.00 for the Committee on Leisure Time Activities and

$500.00 for the Committee on Nomenclature and Statistics.

Executive Committee Meeting, Sept. 19, 1948.—Directed that the chairman of the Committee on Ethics should send his preliminary report to the members of the Council, to Dr. Walter L. Treadway, and to the chairmen of all committees for their consideration and suggestions. Approved the appointment of Dr. Francis H. Sleeper as the new chairman of the Committee on Psychiatric Nursing. Recommended that a method be devised by which quick mobilization of psychiatric opinion in the affiliated societies could be brought about when important issues are at stake in Congress. Advised that the relationship between the APA and the Psychiatric Foundation be clarified to members of APA in the Newsletter, and received the information that preliminary discussions of a proposed merger of the Psychiatric Foundation, the National Mental Health Foundation of Philadelphia, the National Committee for Mental Hygiene, and the Menninger Foundation were under way. Referred the application of the Texas Neuropsychiatric Association, to become an affiliated society, to the Council. Requested Dr. Daniel Blain and Dr. George S. Stevenson to confer and make recommendations concerning psychiatric personnel placement service. Decided to recommend to Council the establishment of a Committee on Therapy. Approved the appointment of Dr. Jacob E. Finesinger, as chairman of the Research Committee, and asked him to appoint a subcommittee to investigate the Wilhelm Reich method of treatment. It was voted to advise the Nominating Committee that the Membership would be interested in the results of the mail ballot for nominations. Approved the suggestion of the President to appoint a committee of members of Council to prepare a long-time financial planning program for the Association. Dr. Robert H. Felix as chairman, Drs. Winfred Overholser, Jack R. Ewalt, Henry W. Brosin, and D. Ewen Cameron were appointed on this Committee, to have its first meeting at Asbury Park, November 15, 1948. Directed that the Biographical Committee enlarge its function and serve also as a committee on the Membership Directory. Approved plans of the chairman with regard to the Asbury Park meeting for a dinner meeting of committee chairmen the evening of November 14, 1948, meeting of standing committees on November 15, a meeting of representatives of psychiatric organizations on the evening of November 15, and Council meeting November 16. It was agreed that a round table for chairmen of mental health committees of state medical societies should be planned for the Montreal annual meeting. Requested further information from Dr. Thomas A. C. Rennie concerning the International Congress for Psychiatry, to be held in Paris in 1950. Approved the appointment of Dr. Nathaniel Warner, of New York, to represent the APA on the National Council on Rehabilitation. Requested the Committee on Psychiatric Hospital Standards and Policies to inform the membership concerning the courses available in hospital administration. Approved the request of the Section on Psychopathology of Childhood to change its name to the Section on Child Psychiatry, and referred this matter to the Council. Authorized the Editor of the Journal to condense the material of the proceedings of the annual and semi-annual meetings (1947-48) and the reports of committees for purposes of publishing in the Journal. Approved the plan of the chairman to change the terms of service for members of committee to a 1-2-3 year term of office, provided the members themselves agreed to such rearrangement. Gave authority to the chairman to write to the Administrator of Veterans Affairs opposing his intention to eliminate psychiatric units in general VA Hospitals.

Executive Committee Meeting, Nov. 10, 1948.—The Medical Director was authorized to publish a list of job vacancies and the establishment of a placement bureau was tabled. Approved recommendations from the Medical Director (1) that the Secretary offer the services of APA to WHO; (2) that APA increase its number of Corresponding Members; (3) participate in the clarification of concepts of international nomenclature; and (4) request the Committee on Psychiatric Hospital Standards and Policies to investigate the aid that psychiatry can contribute toward public health measures in tuberculosis; (5) request the Committee on Preventive Psychiatry to organize material toward public health measures for maternal and child health for the benefit of the WHO.

Recommended against the 1950 meeting of APA in Dallas because of shortage of facilities and requested a list of other cities the Council would approve. Approved the apportionment of $1,200 to the Committee on Public Education, minus the amount which was now standing to their credit. Recommended to the Budget Committee and Council the advisability of changing the fiscal year to be from July 1 to June 30. Referred the recommendation for a survey of public relations at a cost of $3,500, to the Committee on Public Education for reconsideration. Approved the request of the President for permission to invite the Presidents of AMA, American College of Physicians, American College of Surgeons, the Canadian Medical Association, the Canadian Royal College of Physicians and Surgeons to attend the annual 1949 meeting at their own expense. Approved the applications from the Nebraska Society of Neurology and Psychiatry, the North California Society of Neurology and Psychiatry, and the Milwaukee Neuropsychiatric Society to become affiliated societies of the APA. Recommended that attendance at all business meetings of the Association be limited to the membership of the Association.

Council Meeting, Nov. 16, 1948.—Council approved the foregoing actions by The Executive Committee and took action as follows: (1) Voted the acceptance of the applications from the following organizations to become affiliate societies of the Association: Nebraska Society of Neurology and Psychiatry, Northern California Society of Neurology and Psychiatry, Milwaukee Neuropsychiatric Society, Texas Neuropsychiatric Associa-

tion, Indiana Neuropsychiatric Association, Iowa Neuropsychiatric Society, and Washington Psychiatric Society. (2) Voted approval of the recommendation by the Committee on International Relationships that the Constitution of the Association be amended to permit all membership privileges to qualified psychiatrists who reside anywhere in the Western Hemisphere. (3) Voted that the Association charge a nonmembership fee of $5.00 for attendance at the annual meeting. (The Council subsequently amended this action by mail vote to make this effective in 1950.) (4) Voted that annual dues of $10.00 be assessed to all new Corresponding Members, and proposed an amendment to Article V of the Constitution to allow for this procedure. (5) Expressed itself in favor of occupational therapists being included under the provisions of the National Mental Health Act. (6) Approved the reorganization of committees by changing the terms of membership on committees from a 5, 4, 3, 2, 1 year basis to a 3, 2, and 1 year basis. (7) After learning that the estimated expenditure for printing a condensed form of the Proceedings of the Association for 1947 would cost approximately $1,000, Council voted to authorize the Executive Committee to find other means of publishing the Proceedings less expensively and having a certain number of copies available to the members of the Association. (8) Voted the establishment of a Committee on Therapy and a Committee on Resolutions provided that the Budget Committee shall allocate no money to these two committees until specifically instructed by the Council. (9) Approved the following recommendation for presentation to the membership at the next annual meeting: That psychiatrists be encouraged to participate in the affairs of their communities (school boards, church vestries, city council, policy-making conferences in industry, etc.) as citizens and thereby exert a wholesome influence through their knowledge of the field of preventive psychiatry.

Executive Committee Meeting, Dec. 16, 1948.—(1) The investigation of orgone therapy was referred to the AMA, through personal contact by Dr. Daniel Blain and Dr. Leo Bartemeier. (2) The request from the World Medical Association that the APA become a founder-sustaining member was referred to the Committee on International Relationships for further investigation. (3) Recommended that the Association contribute $75.00 to the National Research Council as its contribution for the current year. Recommended that information about the Registry in Pathology and the Atlas on Neuropathology be given some space in the Newsletter, so that members would know this material is available. (4) Agreed on the development of a Manual of Operations for the American Psychiatric Association, to include first the outlines of committee aims and functions. (5) The statement on war from the Committee on International Relationships was approved and plans made to send it to various government officials and other nationally prominent citizens, over the President's signature, as well as releasing it to news writers and press services. (6) Agreed to provide desk space for a representative of the National Committee for Mental Hygiene in the Washington Office, charging the sum of $15 per month for this space, with the understanding that this does not constitute a precedent. (7) Resignations of certain members of the Association were accepted on the recommendation of the Membership Committee.

Executive Committee Meeting, Jan. 23, 1949.—(1) Establishment of a policy for releases to the press was agreed upon on the recommendation of the Public Education Committee, through the office of the Medical Director. (2) The Secretary reported on a letter from Dr. Francis Braceland, Secretary of the American Board of Psychiatry and Neurology, indicating that the Board does not agree to the dismissal of hospital staff members simply because they are not diplomates of the Board. (3) Accepted a recommendation from the Budget Committee that the standard letterhead of the Association be used for all committees instead of special stationery printed for each committee. (4) Passed a motion requesting Drs. Robert Felix, D. Ewen Cameron, and Daniel Blain to make a review of the administrative structure of the Association. (5) Approved of charging an annual subscription of $5.00 for the Newsletter to nonmembers. (6) Approved a recommendation from the Budget Committee that the present Corresponding Members of the Association be charged a subscription fee for the Journal, effective July 1. (7) Approved a recommendation from the Treasurer that: (a) the Treasurer should cease to be chairman of the Budget Committee; (b) the Budget Committee be composed of 3 members of the Council and 2 other members of the Association, and (c) the present *ad hoc* Finance Committee be considered for membership in the Budget Committee. The Budget Committee was reconstituted with Dr. Robert Felix appointed chairman and Drs. Jack R. Ewalt, Winfred Overholser, Frederick W. Parsons, and Clarence H. Bellinger as members. (8) Approved of the participation of the Association (an action already taken by Council in November) in the Inter-Professional Council on Mental Health, and voted to appropriate between $50.00 and $100.00 toward secretarial expenses of such a Council for the current year. The President of the APA was delegated authority to appoint representatives and alternates to represent the APA at further meetings of this Council. (9) After due consideration, voted to recommend to the Council that the APA withdraw from the National Council on Rehabilitation. (10) Approved in principle the establishment of a Hospital Service in the office of the Medical Director, depending on further elaboration of the plan, details of financing, and other details. (11) Voted to make a specific request for a grant from the Commonwealth Fund for the purpose of simultaneous meetings of all committees of the APA, subject to concurrence by the Council. (12) Felt it desirable to give every opportunity to any group or individual who wished to express himself at the annual meeting regarding the reorganization plan, to do so. (13) Ap-

proved in principle of cooperating with the National Junior Chamber of Commerce in planning a National Mental Health Week. (14) Approved of a protest to Dr. George Lull, Secretary of the AMA, and to the Michigan Public Expenditure Survey, regarding the following statement in the booklet, "Uncle Sam, M. D.": "Conditions not preventable or remediable by means available to the medical profession now (includes mental disease, defective vision, some heart ailments, amputation, etc.)." (15) Voted to recommend to the Council that the *ad hoc* Committee on Alcoholism be established as a standing committee in the Association, for such time as the committee feels its function and program necessary. (16) Accepted a recommendation from the Treasurer that the Auditing Committee does not serve a sufficiently useful purpose and recommended that an amendment to the Constitution be prepared to eliminate the existence of this Committee.

Executive Committee Meeting, Feb. 26, 1949.— (1) Agreed that the Membership Directory should be published as soon after the annual meeting as possible, with a supplement attached to it containing the names of members taken in at the Montreal meeting, further agreeing to encumber the necessary funds from the budget of the current year to pay for the printing of this directory. (2) Approved of a recommendation that a cash prize in the amount of $250 be presented by the APA during its coming annual meeting as the award to a superintendent of a mental hospital who had outlined the best program for the care of patients and the management of the hospital, the money coming from funds acquired in connection with the Mental Hospital Institute. (3) In further discussion of the World Medical Association and in view of the fact that practically all the United States members of the APA are already members of the AMA, it was assumed that they are contributing to the WMA through the AMA. Therefore, it was moved that any contribution from the APA should be delayed awaiting further clarification. (4) Approved of a subcommittee of the Committee on Psychiatric Hospital Standards and Policies, composed of Drs. Addison Duval, George Elliott, and Harvey Tompkins, to consider how psychiatry can contribute toward public health measures in tuberculosis. It was further agreed that there should be a close liaison with the Committee on Public Health. (5) At the request of the State Department, approved of extending an invitation to Dr. Luigi Ledda of Rome to attend the annual meeting of the American Psychiatric Association. (6) Approved an invitation being extended to Dr. Henri Hecaen of Paris to attend the Montreal meeting. It was understood in both instances that the expense of these individuals would be from sources other than the APA. (7) In conference with Dr. Clarence B. Farrar, agreed that the committee chairmen should be asked to abbreviate greatly their reports of the 1948 meeting for publication in the Annual Proceedings in the Journal. It was agreed that this was unsatisfactory, but no other course seemed open because of the tremendous expense involved. (8) Agreed that the Constitution should be revised to include a statement describing the necessary qualifications for Fellowship status in the Association. (9) Approved of a request from the Medical Director to increase the space in the Washington Office on the provision that it did not exceed the total budget for the Medical Director.

Executive Committee Meeting, April 6, 1949.— (1) Decided on Detroit as the location for the 1950 annual meeting, provided minor details can be worked out. (2) Agreed to recommend Dr. Thomas A. C. Rennie as a representative of psychiatry on the U. S. delegation to WHO, and as an alternate Dr. S. Bernard Wortis. (3) A request had been received to endorse the recommended budget of $942,550 for a program in mental health of the WHO. No action was taken. (4) Approved of a contribution of $200 to the International Congress of Psychiatry to be held in Paris in 1950 in the name of the proposed Canadian delegation of members of the American Psychiatric Association. This paralleled a previous contribution of $200 which would be regarded as representing the United States delegation. (5) Voted that the Hofheimer Prize Award be presented during the annual banquet by Dr. Nolan D. C. Lewis, Chairman of the Board. (6) Voted that the report of the Psychiatric Foundation be presented during one of the business meetings. (7) Decided on a method of balloting for the officers on Tuesday morning, May 24, and decided to provide a mimeographed ballot sheet listing all the names nominated for officers, including those from the floor. (8) Voted to pay a bill of $21,000 to the Lord Baltimore Press out of general funds of the Association, covering the deficit of the Journal accruing over the last several months. (9) Voted that the Budget Committee be requested to set up a budget of all accounts and activities of the Association—Journal, annual meeting, and membership—to study the question of allocating from the membership account for Journal subscriptions. (10) Passed a motion disapproving a lay superintendent of a mental hospital, and urged the Committee on Psychiatric Hospital Standards and Policies to investigate this question. (11) A motion was passed that there be an official and permanent location in the office of the Medical Director for the files of the Association, with all official minutes, reports, procedures, etc. (12) Upon request, nominated Dr. John R. Rees for the post of Medical Director of the World Federation for Mental Health. A motion was passed that 2 copies of the AMERICAN JOURNAL OF PSYCHIATRY be sent regularly to the Secretary of the World Federation for Mental Health. (13) Moved to request Dr. Mesrop A. Tarumianz to assist in the preparation of a formal application and to secure the signatures of at least 20 members of the Association for the formation of a Section on Administrative Psychiatry. (14) At the request of Dr. Lewis H. Weed of the National Research Council, nominated Dr. Jacob E. Finesinger as a representative on the Division of Medical Sciences of the National Research Council to replace Dr. Harry C. Solomon.

(15) Authorized the Secretary to send copies of a letter, from Dr. Karl Bowman to Dr. Robert McGraw, to the committee chairmen and to the presidents and secretaries of the affiliate societies. This letter contained Dr. Bowman's comments on Letter No. 2 of the Committee for the Preservation of Medical Standards in Psychiatry.

Executive Committee Meeting, May 19, 1949.—(1) Final approval of the 1950 annual meeting to be held in Detroit May 1-5 inclusive. (2) Received the report of the Mental Hospital Institute and expressed commendation to the Medical Director and appreciation to the faculty members for their important contribution. (3) Approval of the job description of the Medical Director. (4) Approval of the job description of the Treasurer. (5) Approval of effort to place Dr. William Crawford Gorgas in the New York University Hall of Fame for great Americans. (6) Approval of Miss Dorothy Clark, R. N., as Nursing Consultant to the Committee on Psychiatric Nursing.

Council Meeting, May 21, 1949.—Council approved the foregoing Executive Committee actions except where noted to contrary and took further action as follows: Approved the suggestion of the Executive Committee that the files from the Secretary's office should be permanently kept in the Medical Director's office and transferred at the convenience of the Secretary. Requested that the Committee on the History of Psychiatry conduct a research into the history of the uses of lay superintendents and medical superintendents in the past among mental hospitals in the United States with a view to setting up a strongly worded precedent on this matter. Requested clarification of the status of the Southern Psychiatric Association as an affiliate society. Recommended further study of Cincinnati as a place of meeting in 1951, instructing the Executive Committee to make plans to do this if it was found to be possible and discuss the possibility of holding the 1952 meeting in either Los Angeles or Florida. Approved the publishing of the proceedings of the Mental Hospital Institute (April, 1949) in an abbreviated form, using the surplus of attendance fees and sales of the book for editing and publishing these proceedings. Indorsed the appropriation of a sizable sum for extending the work of WHO in the mental health field. Held in abeyance the acceptance of the Oklahoma Society of Psychiatry and Neurology to become an affiliate society until it was determined that the Constitution of the Society did not imply sanction of discrimination. Approved the principle that all funds received by the Association would become part of the regular budget and only expendable with due authorization and that this matter be worded by a special committee, mimeographed, and distributed to members. Voted to have published in the Journal the statement from the Neuropsychiatric Society of Virginia regarding schism existing in APA. Instructed the Executive Committee to select one or more representatives to represent APA at the Royal Medico-Psychological Association meeting in York, England, July 1949. Disapproved the establishment of a subspecialty board in child psychiatry or other subspecialty boards. Approved in principle a new APA communication system to be called the Mail Pouch to be tried out for a period of 6 months. Approved the renewal of the lease of the Office of the Medical Director for one year. Appointed Dr. Leo Bartemeier to serve as representative for APA at the World Federation for Mental Health meeting in Geneva, August 22, and Dr. Charles Englander as alternate.

Approved acceptance of the applications of the Pennsylvania Psychiatric Society to be a district branch society of APA for Delaware and Pennsylvania and the Mid-Continent Psychiatric Association to be a district branch society of the APA for Missouri and Kansas.

Approved the recommendation of the Budget Committee that the fiscal year of the Association be changed to run from July 1 to June 30. Voted that no action be taken on the request of Whittaker and Baxter, public relations consultants to AMA, that APA pass a strongly worded resolution opposing compulsory health insurance and referred this matter to a special committee to report back to the Council. Requested the Secretary to work out with the chairman of the Committee on Psychiatric Hospital Standards and Policies a scheme of organization with that Committee and the Central Inspection Board using the current report of that Committee as a basis.

Approved the establishment of a Section on Administrative Psychiatry for the annual meeting.

Council Meeting, May 22, 1949.—Authorized the Committee on History of Psychiatry, through its chairman, to publish an issue of the Centenary Volume in England and on the continent at no cost to the Association. Instructed this Committee to proceed with the Committee on Legal Aspects of Psychiatry to put into effect the proposal of the Isaac Ray Lectures.

Approved the following functions and objectives of the Committee on Public Education: (1) To coordinate and give leadership to present activities insofar as possible. (2) To develop new projects for reaching and informing the various publics. (3) To interpret known psychiatric facts in a way which will be helpful and constructive to individuals comprising the various publics. (4) To adopt a constructively aggressive program, rather than a defensively destructive one. (5) To be alert to public crises, so that sound psychiatric interpretation may be quickly available. (6) To develop a network of important public information contacts. (These functions and objectives were approved by the membership of the Association.) Voted to admit the press to the business meetings of the APA.

Approved on the recommendation of the Committee on Clinical Psychology, the following principles: (1) The Council of the APA is opposed to independent private practice of psychotherapy by clinical psychologists. (2) The Council feels that psychotherapy, whenever practiced by clinical psychologists, should be done in a setting where adequate psychiatric safeguards are provided

Approved the position taken by the Committee on Cooperation with Lay Groups in cultivating the development of the "Gray Lady Service" in the mental hospitals. Expressed appreciation to the members of the Nominating Committee for their efforts, and noted that one nominee for Council, Dr. Nathan K. Rickles, had withdrawn his name from the list of nominees. (He was later nominated by another group.) Referred the request of the Committee on Medical Rehabilitation for information concerning its responsibilities to the Manual of Operations now in process of development. Referred the preliminary report of the Committee on Ethics back to the Committee for further refinement and condensation and suggested that affiliate societies and others interested be invited to comment.

Voted that Corresponding Members be charged $10.00 annually for the Journal, commencing January 1949. Approved a study of the possibility of establishing a "paid-up life membership." Refused to approve the establishment of an initiation fee for new members. Voted that the Committee on Membership be empowered to use its own judgment in the selection of members who are not licensed to practice medicine but that they not be automatically excluded. Recommended an amendment to the Constitution to establish a new category of membership known as "inactive status." Recommended the election of Dr. Ernst Kretschmer of Germany to Honorary Membership. Voted that Dr. Henry Maudsley of Australia be made a Corresponding Member. Voted that Dr. Harry R. Reynolds' dues be remitted for the coming year and reconsidered the following year. Requested the Membership Committee to review the list of candidates proposed for various types of membership to include those being deferred on account of not having a license. Accepted the list of new Associate Members, Members, and Transfers in various categories recommended by the Committee on Membership, with the revision mentioned above. Approved certain recommendations to the membership for proposed amendments to the Constitution (these were printed in the August 1949 issue of the Journal). Voted appreciation to Dr. Travis E. Dancey and the Committee on Arrangements. Instructed the Secretary to communicate with the proper officials of the United States and Canada urging support of the WHO program, in all its phases.

Authorized the incoming President to appoint 3 members of the Council to the CIB and the remainder of the Board to continue their work for at least 5 years.

Approved the request of the chairman of the Committee on Psychiatric Social Work to endorse the efforts of Colonel John M. Caldwell, Jr., to press for the use of psychiatric social work consultants in areas where there are military installations.

Voted to appoint a special committee to assist the Budget Committee to make final recommendations regarding the Journal in order to place it on a better financial basis.

Council Meeting May 25, 1949.—Authorized the renewal of the contract of the Journal with the Lord Baltimore Press for one year at a rate of 10% less than that now in force. Deferred action on the publication of articles in foreign languages and referred this to the Special Committee on Publications and empowered the Editor to print short notes within his discretion in other languages in the Journal. Elected Dr. George H. Stevenson to succeed himself as representative of APA on the American Board of Psychiatry and Neurology. Voted the establishment of a standing Committee on Child Psychiatry. Elected the following to Membership Committee: Dr. John P. S. Cathcart for 5 years, Dr. Francis J. Gerty, 4 years, Dr. Robert B. McGraw, 3 years, Dr. William H. Dunn, chairman, 2 years, Dr. Lawrence Kolb, 1 year. Authorized the President-elect to appoint Dr. Paul Huston to become the official representative of APA at a conference of educators in clinical psychology. Elected Drs. Robert Felix and William Malamud to the Executive Committee.

Council Meeting May 26, 1949.—Approved the application of the Maryland Psychiatric Society as an affiliate society. Voted to leave the participation of the APA in the International Conference on Psychiatry in Paris, 1950, to the incoming President.

Accepted the report of the Budget Committee and adopted the budget for 1949-50 (this report was included with committee reports). Approved the completion of the Biographical Directory although a deficit would ensue, on the basis that it was better to have a Directory and a deficit than to have an equal deficit alone. It was proposed that the prepublication price be $10.00 and publication price $12.50. Approved the completion of the Membership Directory, with a supplement next year rather than a complete revision. Approved the request that $3.00 be transferred from the dues of each of the members and from the membership account to the Journal account and a notice to that effect be sent out. Instructed that no appropriations be made to the Committees on Arrangements, Budget, and International Relationships. Agreed that appropriations to the Office of the Medical Director and Executive Assistant should each be a lump sum with permission to transfer funds from one item to another within the total amount allocated. Voted a complete reorganization of the accounting procedure.

Accepted the principle that the Executive Committee has authority to spend only from the budget sums appropriated to the Council itself and may not obligate other funds of the Association. Requested the Chairman of the Budget Committee to present a brief outline to the membership the following day. Approved the resolution suggested by Drs. Thomas J. Heldt and Lauren H. Smith of the Committee on Ethics that the Provisional Credo and Code of Ethics be mimeographed and sent to all officers, chairman of standing committees, 2 copies to each affiliate society, and that other copies be made available to members at cost by the Medical Director's office and that suggestions be requested from all members not later than February 15, 1950.

Accepted the report of the Executive Assistant that 1,264 members had registered; 1,656 nonmembers, making a total of 2,920. Agreed to the appointment of Dr. Gregory Zilboorg to represent the APA as official representative to attend the laying of the cornerstone at the new hospital in Haiti during the month of June, at no expense to the Association.

Approved the action of the Executive Committee to apply to the Commonwealth Fund for a grant of $24,500 to establish the Mental Hospital Service within the APA. Approved the application for funds to the Commonwealth Fund for a second meeting of all committees of the APA (copies of the applications for both of these grants were presented to each member of the Council). Agreed on the principle that Council should be consulted for approval of a request for any type of grant. Voted to defer action on the request of Dr. Samuel R. Moreno of Mexico City for the establishment of a Latin-American Division pending changes in the Constitution, which would extend the scope of membership to all the Americas. Approved the following job description for the Medical Director:

"The Medical Director shall be a psychiatrist and a Fellow of the APA, nominated by the Executive Committee and appointed by the Council. He shall operate under the immediate direction of the President, under the authority and supervision of the Council, shall attend all meetings of the Executive Committee and Council, and shall be prepared to furnish information, advice, and suggestions.

"The function of the Medical Director shall be to promote the interest, activities, and objectives of the Association by means of coordination, stimulation, liaison, public education, public relations, the assembling and disseminating of information, and special services and activities both for the membership and in behalf of the public welfare within the area of mental health. He shall speak for the Association only along lines of generally accepted policies and when directed by the President, or with his approval.

"The Medical Director shall be senior to and responsible for all employees of the Association and their activities, except employees whose direction is otherwise specifically provided, in which cases he shall be kept informed of their activities.

"The Medical Director shall be responsible for staff work in development of the annual budget, and for recommendations regarding the limitation of expenditures and transfers within the budget. He will prepare periodic financial statements as requested by the Treasurer with the help of the Executive Assistant.

"The Medical Director shall concern himself with committee activities, information services, library facilities, journalistic activities, membership, and affiliate societies. He shall also represent the APA, unless other provision is made, with outside private, government, and international organizations."

Dr. Winfred Overholser moved and Dr. Samuel Hamilton seconded the motion to put on the record the assiduous devotion to duty of the Council, whereupon the Council adjourned at 12:30 a. m., May 27, 1949.

CLINICAL NOTES

A PRELIMINARY REPORT ON THE EFFECT OF DRINKING IN TWENTY-FIVE CASES OF EPILEPSY[1]

DAVID GEDDES, M. D., WASHINGTON, D. C.

It has been recognized for some time that convulsive seizures occur in a significant percentage of cases of chronic alcoholism(1). These are patients who were alcoholic long before they developed fits. It has also been said that alcoholism is one of the prominent predisposing factors in epilepsy, particularly in middle age(2). Thus it seemed timely to evaluate the experience with alcohol of a group of idiopathic epileptic patients.

Twenty-five adult epileptic patients who admitted regular drinking were chosen at random in the seizure clinic of the New Haven Hospital Psychiatric Dispensary. They were questioned concerning their drinking and its relation to their seizures. In none of these people was alcohol so serious a problem that they were prevented from working or living comfortably at home. There was only one patient who drank to excess, and this occurred on weekends. All the patients had a history of some epileptic seizures previous to the onset of regular drinking. Thus no patients were queried whose convulsive episodes began after they commenced to drink regularly. The results of this report apply only to patients having somatic-motor seizures, since there were no cases of somatic-sensory, visceral, or psychical seizures in the group questioned. Electroencephalographic records for all the patients were obtained. Eighty percent had tracings that were compatible with or suggestive of epilepsy.

It seemed important to discover whether alcohol alleviated or aggravated the seizures in these patients. Of the 25 patients 7 felt that liquor would abort a seizure, and they reported that they drank alcohol if they felt a seizure was imminent. Three patients believed that drinking sometimes brought on a seizure. In these 3 cases a seizure occurred within 24 hours of drinking alcohol. The remaining 15 could see no effect one way or another on their seizures regardless of the amount of alcohol they drank.

The effectiveness of the treatment in these drinking patients was considered. All were on dilantin sodium in varying dosages. With the dilantin some of the patients took additional medication. This included phenobarbital, paradione, hibicon, and phenurone. Twelve patients were found to be very effectively controlled (fewer than one seizure a year), 5 patients were moderately effectively controlled (fewer than one seizure a month), and 8 were fairly effectively controlled (more than one seizure a month). In our experience this compares favorably with the effectiveness of epilepsy medication in adults where alcohol is not taken.

This work suggests that, in the majority of the adult epileptic patients studied, alcohol had little or no effect upon the frequency or severity of their seizures. One wonders whether these results would apply to adult epileptics in general. Although the convulsive thresholds of these patients must be considerably lowered by their disease, the amount of alcohol that they take in the course of regular moderate drinking is apparently insufficient to produce fits in most cases. This may be partly due to the fact that as the patient grows older the convulsive threshold rises(1). Most epileptics who drink are in the group and may be presumed to have higher convulsive thresholds. It was interesting to see that in most cases moderate regular drinking did not interfere with fairly effective control of their seizures by medication.

[1] From the Department of Psychiatry and Mental Hygiene, Yale University School of Medicine.

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CORRESPONDENCE

A CHALLENGE TO AMERICAN PSYCHIATRY

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: The current public interest in psychiatry, as manifested by magazine articles, pictures and cartoons, contemporary literature and moving pictures, offers us as psychiatrists a challenge for direct action.

It is a challenge to us to gain public participation in problems of research and care of the mentally ill in America, who fill 55% of all our hospital beds. The public participation in the "March of Dimes," the Christmas Seal sale and the drives of the American Heart Association and American Cancer Society have not only secured funds for these purposes but, more importantly, have enlisted each donor, to some extent, as a participating member in the fight against these diseases.

None of us as psychiatrists feel anything but the greatest sympathy for the victims of these diseases, but the general public is not aware of the fact that there are at least three times as many mentally ill patients needing help as there are victims of all of these four diseases combined.

Not one of us would desire to have the funds for research in infantile paralysis, tuberculosis, heart disease, or cancer reduced. However, we should all utilize this current public interest in campaigns for the benefit of the mentally ill. This public participation has made available for the "polio victim" more than 100 times the funds available to the mentally ill patient. The cancer patient has 10 times more for this purpose and the patient with tuberculosis has approximately 25 times more than is available to the mentally ill patient.

During the hearings on the National Mental Health Act in 1946 it was demonstrated that, for every dollar spent on psychiatric research, $65 was spent on other medical research and $2,500 on industrial research.

When it is remembered that the number of psychiatric patients is so great as to fill more hospital beds in America than all other conditions combined, it becomes obvious that these patients are being deprived of the full measure of the American public's interest and participation.

However, this public participation in the care of our patients has not been attained. It certainly is not due to apathy on the part of the general public but possibly to a lack of leadership on our part.

Perhaps a fund drive or seal sale for the benefit of the mentally ill at Thanksgiving would be appropriate. Surely, this is a challenge of the first magnitude to American psychiatry.

CRAWFORD N. BAGANZ, M. D.,
Lyons, N. J.

RE ANTABUSE

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: Dr. Addison M. Duval has called my attention to the fact that in the progress report on alcohol for the year 1949 in the January, 1950, issue of the AMERICAN JOURNAL OF PSYCHIATRY I did not mention that "Antabuse" is a drug that is still in the experimental stage and that cannot be purchased in the open market. Having worked with the drug for the last 9 months, I was thoroughly familiar with this point, but had assumed that this fact was generally known so I did not mention it. In case, therefore, any readers of the JOURNAL are not familiar with this point, it should be made clear that "Antabuse" is still in the experimental stage, that the United States government has not yet approved its sale as a drug available to physicians, and that any work that has been done or is being done is on the basis of the drug having been given to those working with it by the drug firm sponsoring this drug.

KARL M. BOWMAN, M. D.,
San Francisco, Calif.

COMMENT

THE PSYCHOSOMATIC DILEMMA

At the meeting of the American Neurological Association last June a morning was devoted to cerebral localization. In this symposium distinguished investigators from several medical schools delivered and discussed papers of importance. They were professors of anatomy, physiology, psychology, neurology, and neurosurgery. The term "somatic" kept cropping up and it soon became apparent that this word was used to mean different things by different speakers. Since "psychosomatic medicine" has taken such an important role in the advance of psychiatry in recent years, it seems worth while to clear our decks and see if we know just what we are talking about when we discuss "psychosomatic" problems.

To begin with Webster, his dictionary defines "somatic" in three ways: (a) pertaining to the body as a whole, (b) pertaining to the soma or somatic cells, and (c) pertaining to the wall of the body. A somatic cell is defined as "one of the cells of the body which becomes differentiated and composes the tissues . . . distinguished from germ cells." This is not very helpful. There are three possible uses: the body as a whole, the whole body minus germ cells, and the body wall.

Let us turn now to neurological usage. This is based on phylogeny and embryology and the division of the body into organs and tissues derived from the somatopleur and those derived from the splanchnopleur. The former are termed somatic and the latter visceral. The somatic tissues are originally body wall and develop into trunk, limbs and most of the skeletal muscles. The visceral tissues develop into the respiratory, circulatory, and digestive tracts and the special muscles and glands related thereto. C. J. Herrick, a great scholar and dean of American neurologists, divides the nervous organs into two great groups: "(1) a somatic group pertaining to the body in general and its relations with the outer environment, and (2) a visceral, splanchnic or interoceptive group." "The somatic group comprises the greater part of the brain and spinal cord and the cranial and spinal nerves, or, briefly, the cerebrospinal nervous system." In other words the viscera ("the internal organs, especially those concerned with the internal adjustments of the body") are not somatic. This is the terminology most of us were brought up on when we began studying neurology. It is based on scientific work and has many pedagogical advantages. For example, the separation of the "somatic sensory" system from the "visceral sensory" made clear the anatomy and physiology and spared us the confusing concept of "sensory sympathetic nerves" when the sympathetic system is usually accepted as a purely motor system.

Let us now turn to the modern concept of "psychosomatic medicine." A glance at the program of the Association for Research in Nervous and Mental Disease for December 1949 shows one that "life stress" is related to "bodily disease" in many ways, the commonest effects being on the visceral functions. Much of life stress is psychological, and here is where psychosomatic problems come in. But if a neurological purist practiced psychosomatic medicine he would have to confine himself to the spasms, tics, and pains of the muscles and joints, which, important and common though they may be, are at present a small fraction only of the great crowd of visceral symptoms that hold the stage in psychosomatic medicine.

If we have such divergent views on "somatic," what of the other half of the word, "psycho"? Obviously the definition of "psyche" is much more difficult. If we cannot agree on a simple concept like "somatic," what hope is there of getting a working concensus upon the definition of mind? Joining the two words into one more than doubles the difficulty.

It is not our aim to point out what is right and what is wrong in the use of these words. In fact this would be a naive procedure, because in accepting a definition we are not

asserting a statement that can be true or false. We are agreeing to follow an optional convention, on which we want to agree for mutual benefit. There is no right or wrong. We merely agree and go ahead.

What if we do not agree and still go ahead? In fact that is just what we are doing in several fields of psychiatry at present. Psychosomatic medicine is only taken as a glaring example of loose talking and loose thinking. If the aim of science is to advance knowledge and understanding, we are doing little good by perpetuating misunderstandings. Many, if not most, of the emotional arguments could be eliminated at our meetings if only we would begin by defining terms. Often at present we literally do not know what we are talking about!

It would be helpful if we could agree on an operational definition of the adjective "psychosomatic." Perhaps the following might serve:

Pertaining to that field of medicine (a) where psychological and psychiatric data aid in the understanding and treatment of medical symptoms, and (b) where physiological processes aid in the understanding and treatment of mental symptoms.

In this definition "medical symptoms" are taken to mean those that are commonly treated by an internist. "Psychological" is contrasted with "physiological" only in the sense in which those two disciplines are usually separated in a university catalogue. Both are, of course, divisions of biology with much overlapping material. "Mental" is used as synonymous with "psychological" and "mental symptoms" are those indicators of disordered behavior that are usually called emotional, intellectual, or personality disturbances.

It is perhaps annoying that when one goes into definition he has to go through with it and leave no stone in the mosaic unpolished. But that is the price of thinking about things. If we bother to think at all we might as well see it through and really be clear as to just what we are talking about!

S. C.

PSYCHIATRY FOR THE READING PUBLIC

The question of the best means of presenting medical, and particularly psychiatric, information to the public is an old one. Thus L. W. Belden in publishing "An Account of Jane C. Rider, the Springfield Somnambulist," in 1834 states that "it was originally my intention to make the extraordinary case the subject of a communication to one of the Medical Journals; and on that account, though frequently solicited, I have uniformly declined to furnish a statement to the newspapers." "From the wide circulation that has been given to the partial accounts which have already appeared, it is believed that a curiosity to see an authentic narrative of this truly remarkable case has been excited in many, who would have little relish for a purely medical essay. It is submitted to the public with a history of her case since her residence in the Lunatic Hospital which has been obligingly communicated by the distinguished gentleman who presides over that Institution" (Dr. Samuel B. Woodward—one of the founders of The American Psychiatric Association).

This is essentially the problem that confronts psychiatrists on many occasions today, for the interest of the public in mental disorders has been enormously stimulated and whetted by the introduction of psychiatric approaches to social problems and education, and brought directly to the individual through the psychiatric screening of soldiers in the recent World War. The interest is reflected in a flood of psychiatrically hued popular articles, radio talks, television presentations, stories in the pulp magazines, and novels. Some of the latter are essentially embellished case histories; others are penetrating psychological character delineations or studies of occurrences and situations dependent upon neurotic involvement.

Patients frequently are impelled to consult a psychiatrist because of some newspaper account that mentions psychiatry, or may be brought for treatment by a near relative who recognizes in the patient characteristics that have led some person described in an account in a tabloid to social disaster. Patients in actual treatment will often refer to identifica-

tions or empathies that they have experienced with characters or situations in novels, or with cases reported in popular books on psychiatry. Among these works of fiction may be mentioned two recent successes, "The Rage to Live" by O'Hara and "Killers of the Dream" by Lillian Smith, and among popular presentations, "Peace of Mind" by Liebman and "The Mature Mind" by Overstreet. When the patient under treatment mentions such books to the psychiatrist, the relation of the situations that have impressed him may be discussed and analyzed with therapeutic effect. However, the general public is misled at times by distorted, even absurd descriptions and oversimplified solutions of psychiatric situations. Possibly it would be of some value to compile a list of novels, mellowed through the years, that best portray frequently encountered psychiatric problems and conflicts, such as Somerset Maugham's classical description of youthful sexual dilemma, "Of Human Bondage," or Samuel Butler's amazingly analytic pre-Freudian study of parental repression, "The Way of All Flesh." Some of the books in such a selection might be suggested or required reading for undergraduate students or as supplementary reading for graduates.

It is not desirable to attempt to censor the public's reading of psychiatric literature, whether rubbish or authentic. On the other hand it would seem distinctly worth while for The American Psychiatric Association to select each year from the vast number of books and stories that appear a list considered best adapted to convey the true possibilities of the psychiatric approach with the objective of making easily accessible to the reader fiction where imagination does not too far transcend reality and expository articles where profundity and linguistics do not confuse or bore him. Such a list would include separate classes of psychiatrically oriented fiction ranging from Proust and Virginia Woolf to stories appearing in pulp magazines; from well-written popular books, such as "The Human Mind," to more simple and dramatically presented psychiatric accounts that appear in the Sunday supplements. Such a selection should not be designed for sociological, literary, or psychiatric journals but so assembled that it would appeal to the average reader. It could be sent to newspapers throughout the country and be on file in general and scientific libraries.

C. P. O.

NEWS AND NOTES

GERMAN NEUROLOGICAL AND PSYCHIATRIC ASSOCIATION.—The third meeting of this society since the war was held in Göttingen September 22-25, 1949, under the presidency of Ernst Kretschmer. One of the most interesting communications was the discussion by Rylander (Stockholm) of personality changes following leucotomy, there being still but little material of this kind for observation in Germany. On the basis of his extensive experience with this treatment method in Sweden, Rylander stated that the operation definitely produced an alteration in the patient's personality but not of such character as to contraindicate the operation in properly chosen cases. There was general concurrence in this view.

The third day of the meeting was devoted to the subject of psychotherapy. General approval greeted the presentation of Rümke (Utrecht) titled, "What Is Psychogenic in the Neuroses and What Not?" Rümke was in essential agreement with Winkler (Tübingen), who spoke on constitutional variants and neurosis, in the opinion that constitutional, biological, developmental, and somatic factors play important roles in the neuroses; and that certain constitution variants, especially sexual types, determine a characteristic and specific form of neurosis with physical and psychic factors mutually interactive. The mutual relations of physical and psychic factors were illustrated from many points of view as of fundamental importance.

The German society includes four sections: neurology, neurosurgery, psychiatry, and psychotherapy. The society as a whole with all sections participating will in future meet every second year, the sections holding their individual meetings in the intervening year.

WORLD FEDERATION FOR MENTAL HEALTH, 1950 MEETING.—The third annual meeting will be held in Paris, by kind invitation of the Ligue d'Hygiene Mentale, from Thursday, August 31, to Thursday, September 7, inclusive. The first six days will be devoted to the discussion of scientific topics primarily in small working groups. Main topics to be considered are: mental health in education, occupational and industrial mental health, mental health problems of transplanted and homeless persons, and problems of leadership and authority in local communities.

The administrative sessions will be held on September 6 and 7. The executive board of the Federation will meet August 27-30 and September 8 and 9.

Expected to attend the annual meeting are the delegations appointed in each country by the convening organization, and any other members of member-associations who are able to be present. Hotel reservations should be made direct or through the usual travel agencies. A certain number of students' rooms will be available, and these will be allocated in order of application, which should be made to the Secretary of the Federation, 19 Manchester St., London, W.1.

PROBLEMS OF EXCEPTIONAL CHILDREN.—The fourth annual Conference on Mental Hygiene and Problems of Exceptional Children will be held on May 12 and 13 at Syracuse University. It is sponsored by the School of Education, the Department of Special Education for Exceptional Children, and the Mental Hygiene Clinic of the Psychological Services Center, Syracuse University. The theme of the meetings will be "The Prevention of Maladjustment."

Among the speakers at the Conference will be Stanley Estes of Harvard University, Bela Mittelman of New York University, David Rapaport of the Austen Riggs Foundation, Fritz Redl of Wayne University, Wendell Johnson of the University of Iowa, Lauretta Bender of New York University, Kimball Young of Northwestern University, and Ralph Linton of Yale.

For further information write to Leon Gorlow, Psychological Services Center, 125 College Place, Syracuse 10, N. Y.

PSYCHODRAMA CONFERENCES.—Three conferences dealing with psychodrama, sociometry, and group psychotherapy will be held at the Psychodramatic Institute, Beacon, N. Y., on the following dates: first conference, April 8-10, 1950; second, May 27-30, 1950; third, July 1-4, 1950.

Fees: $17.50 one day, $25.00 two days, $35.00 three days, and $42.50 four days. For further information write to the Moreno Institute, Beacon, N. Y.

CREEDMOOR INSTITUTE FOR PSYCHOBIOLOGIC STUDIES.—On February 9, 1950, Ambassador Carlos P. Romulo officiated at the dedication of the Creedmoor Institute for Psychobiologic Studies at Creedmoor State Hospital, Queens, N. Y. The new clinic is designed to treat not only severe psychiatric disorders but also psychoneuroses manifested in psychosomatic disease. Most treatment will be outpatient, but some open wards and metabolic units will be provided for short periods of hospitalization. The clinic will specialize in histamine, steroid, and insulin therapy, as well as give psychotherapy and modifications of shock treatment.

Director of the new Institute is Dr. Johan H. W. van Ophuijsen. Dr. Co Tui has been appointed director of biologic research, and Dr. Arthur M. Sackler general director of research.

Dr. Harry A. La Burt, senior director of Creedmoor State Hospital, stated, "We hope to make the Institute an advanced center for discovery of new diagnostic and therapeutic techniques through further determination of the familial, biochemical, and hormonal patterns in mental disease."

ROFFEY PARK REHABILITATION CENTRE.—Two international courses on occupational health and rehabilitation are planned by this English institution for the summer of 1950. The courses, scheduled for July 17-24 and August 14-21, are planned for all those concerned with the social and medical problems of industry.

Attendance is limited to 25 persons, who will be accommodated at the Centre. Roffey Park is 35 miles from London. The fee, which includes tuition and full residence, is $30. Applications should be made to the Secretary, Roffey Park, Horsham, Sussex, England, stating preferred week.

The Rehabilitation Centre, of which Lord Horder is chairman and Dr. T. M. Ling is medical director, provides resident treatment and resettlement facilities for 120 cases coming from hospital outpatient departments and from industrial medical officers.

AMERICAN GENETIC ASSOCIATION OFFERS PRIZE.—This Association announces a prize of $1,000 for the best essay written during 1950 in partial answer to the question, "Who marries whom, and why?" It is hoped that the contest will clarify some of the social, economic, and educational factors which are important in determining marriage choices. The competition is open to all qualified students and specialists in this field. The contest closes February 28, 1951. For additional information write to the American Genetic Association, 1507 M Street, N. W., Washington 5, D. C.

DR. ROSSEN NEW COMMISSIONER OF MENTAL HYGIENE FOR MINNESOTA.—Announcement has been received of the appointment of Dr. Ralph Rossen as Minnesota's first Commissioner of Mental Hygiene. For twelve years preceding this new appointment Dr. Rossen was superintendent of the State Hospital at Hastings. He spent 2½ years in the Navy during the war and did considerable research at the Naval Hospital, Bethesda, Md., in electroencephalography.

Dr. Rossen is described by Dr. Eric Kent Clarke as "a very dynamic, energetic individual who has run an excellent hospital, is keenly interested in research, and is anxious to develop a program of prevention with children."

DR. HUNT TO DIRECT ST. LAWRENCE STATE HOSPITAL.—Appointment of Dr. Robert C. Hunt as director of St. Lawrence State Hospital, Ogdensburg, N. Y., effective March 1, 1950, has been announced by Dr. Frederick MacCurdy, Commissioner of Mental Hygiene. Dr. Hunt succeeds Dr. John A. Pritchard, recently retired after 10 years in charge of the hospital.

Since 1935 Dr. Hunt was assistant director of Rochester State Hospital, except for mili-

tary leave of absence from 1942 to 1946. He is now a lieutenant colonel in the U. S. Army Reserve. Before joining the staff at Rochester State Hospital he had been attached to Strong Memorial Hospital, Rochester, Binghamton State Hospital, and the Institute of the Pennsylvania Hospital, Philadelphia.

INDIANA NEUROPSYCHIATRIC ASSOCIATION.—At the May 29, 1950, meeting Dr. Leo Bartemeier of Detroit, secretary of the American Psychiatric Association, will speak on "The Psychology of Disturbances of Sleep." The meeting will take place in Indianapolis. For further information write to Dr. D. W. Schuster, 723 Hume Mansur Bldg., Indianapolis 4, Ind. Those desiring hotel reservations should apply at once.

ARIZONA SOCIETY OF PSYCHIATRY AND NEUROLOGY.—Dr. Tracy J. Putnam was guest speaker at the regular meeting of this Society at the Tucson Medical Center, Tucson, Arizona, on March 18, 1950. His subject was "The Treatment of Epilepsy."

CATHOLIC PSYCHIATRISTS TO ORGANIZE.—A guild of Catholic psychiatrists is in the process of being organized. Any Catholic psychiatrist who is a member of the American Psychiatric Association, and who would be interested in joining this group, should communicate with Dr. Edward L. Brennan, 56 Garden St., Hartford, Conn.

ARMY MEDICAL LIBRARY.—Major General R. W. Bliss, the Army Surgeon General, announces that a revision will be made in the near future of the Army Medical Library's plans for the publication of medical indexes toward a system more in keeping with modern medical indexing requirements. The Index-Catalogue of the Library of the Surgeon General's Office, which was begun in 1880, lists alphabetically all author, book, pamphlet, and journal article titles of the medical and allied fields available in the Library. Certain changes in procedure will bring the Index more up to date. At the same time, the Library's Current List of Medical Literature will be augmented and improved to provide more effective service. The Library's traditional interest in the historical side of the medical sciences will continue.

FOWLER MEMORIAL LECTURES, ORANGEBURG, S. C.—The initial series of the Fowler Memorial Lectures was held at Edgewood Sanitarium, Orangeburg, S. C., February 10, 1950. The purpose of this annual lectureship is to extend medical information to the general public in accordance with the Ten-Point Program of the South Carolina Medical Association.

The program was arranged by Dr. Orin R. Yost, psychiatrist-in-chief of Edgewood Sanitarium, who as an affiliate of the National Committee for Promoting Observance of Mental Health Week will again assist the South Carolina Junior Chamber of Commerce in planning for observance of Mental Health Week April 23-29.

Dr. Nolan D. C. Lewis, director of the New York State Psychiatric Institute and Hospital, the principal guest speaker, discussed present research trends in psychiatry. The program included both general medical and psychiatric topics.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION.—The Association is now carrying on a recruitment program in 45 states, with the purpose of stimulating school enrollment in the 25 schools of occupational therapy approved by the American Medical Association. Recruitment committees furnish information on career training to vocational guidance units in state departments, high schools, and colleges. Thus the nationwide need for additional therapists may be eventually filled. Suggestions for planning a career in occupational therapy may be obtained from recruitment committees in the various states or from the American Occupational Therapy Association, 33 W. 42d St., New York 18, N. Y.

BOOK REVIEWS

DUODENAL ULCER: A SOCIOPSYCHOLOGICAL STUDY OF NAVAL ENLISTED PERSONNEL AND CIVILIANS. By *Jurgen Ruesch, M.D., et al.* (Berkeley and Los Angeles: University of California Press, 1948.)

This is a study of personality characteristics and environment of patients with duodenal ulcer. Twenty civilians and 42 Navy enlisted men with duodenal ulcer, as shown by X-ray, were studied at the Langley-Porter Psychiatric Clinic of the University of California Medical School. The study included 8-10 controlled interviews, psychological tests, and autobiographies.

The 114 pages of the text are crowded with pertinent material derived from comprehensive investigations of the patients' reaction to family environment from early childhood onward, their attitudes in other environments and life situations, their social, economic, and cultural status. Out of the multifarious findings the authors have constructed personality profiles of the ulcer patients and outlined the dynamic factors in the formation and development of those profiles.

To the reviewer, certain inferences drawn from the psychological methods of study are challenging: It appears highly questionable that ulcer patients "differ in personality characteristics from the normal population" if one is mindful of the wide range of normals in a normal population. It is also difficult to accept that "the capacity for repression and dissociation" is more typical of duodenal ulcer patients than of certain normals without ulcer or any other physical illness. Besides, "capacity for dissociation and repression" does not make one a deviant from the range of normals. Then, it is also hard to see why the personality structure of the Navy ulcer patients should, in important respects, differ so markedly from that of the civilian ulcer patients. Have the Navy enlisted men, up to their enlistment, been very special, *sui generis*, civilians? Or, has the Navy, in a relatively short time, reshaped their personalities? And if one admits that the Navy ulcer patients' "primitive, simple kind of ego-organization, psychological obtuseness, and lack of easy adaptability in their social techniques" are specific dynamic factors contributing to the formation of ulcer, wouldn't one expect to find similar personality traits nearly as frequently also in the civilian ulcer patients?

The reviewer is also and particularly impressed by the very significant differences between the naval and civilian patients in their family relationships, as elicited from the patients' memories, from the third year of life: a dominant mother and an uninfluential father in the Naval patient; an idealized mother and a punitive father in the civilian patient. How is one to explain those contrasting family patterns, considering the fact that up to their enlistment, the Naval men were civilians? Assuming that specific family constellations may contribute to Naval enlistment, it remains unclear why such opposite family situations are regarded as specific dynamic factors in the formation or development of duodenal ulcer? It would make sense to the reviewer if the authors were to speak of emotional disturbances—conscious and subconscious ones—without any further specifications of the nature of the emotional disorders.

In brief, it is my feeling that the personality characteristics of the ulcer patients, "dependence, conformity, overtly counteractive, covertly passive, hungry for love and affection, lack of needs for acquisition, order, construction, not avoiding blame," if looked for zealously as the authors did, are likewise to be found in equivalent groups of individuals without duodenal ulcer or any other organic disease.

Dr. Ruesch and his research group have contributed pertinent and very significant material to our knowledge in psychosomatic medicine. It should be recognized, however, that the actual state of our knowledge, as yet, does not allow to build personality profiles for duodenal ulcer or any other illness. The questions raised in this review illustrate how thought-provoking this volume is. It is to be expected that it will stimulate further studies.

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DEMENTIA PRÆCOX. By *Leopold Bellak.* (New York: Grune & Stratton, 1948.)

This volume represents a summary review of the accumulated literature appearing between 1936 and 1946 dealing with dementia præcox. About 3,200 articles were reviewed and the bibliography conveniently placed following each of the 20 chapters. This work followed the very complete report on dementia præcox made by Nolan D. C. Lewis that covered the preceding 10-year period entitled "Research in Dementia Præcox (Past Attainments. Present Trends and Future Possibilities)."

The first several chapters deal with Definition and Description, Vital Statistics, Etiology, Pathogenesis and Pathology, Diagnosis and Symptomatology, Physiological Studies, and Psychological Studies. For current definitions we are referred to those of Hinsie and Shatsky, Meyer and Despert. A number of papers reported clinical cases of schizophrenia that were later established to be clear-cut cases with organic brain pathology. The wide variety of etiological factors reported led Bellak to consider the clinical psychopathology described as schizophrenic as actually a syndrome or reaction type. He postulates a psychosomatic view of schizophrenia, believing that one must consider the relative prominence of (a)

somatic predisposition, (b) sociopsychological predisposition, (c) psychological precipitating causes, and (d) somatic precipitating causes. Schizophrenia he considers as a predominantly psychogenic reaction having a better prognosis. It is characterized by sudden onset in a rather adequate prepsychotic personality, the presence of precipitating factors, and with confusion, catatonic symptoms, and some affective features prominent in the clinical picture. He considers as dementia præcox those cases with a maximum of somatic, constitutional predisposition, cases with a poor prepsychotic history, insidious onset, and inadequate affect.

Physiological studies are felt to be difficult to interpret. The most significant observation seems to be that "almost any data observed showed a greater variability than in normals."

Therapy is extensively reviewed in all its aspects with much space given to the shock therapies, insulin, metrazol, and electroshock. Rates for over-all improvement without shock treatment cluster around 40%. The majority of the papers seem to point to an over-all improved prognosis with shock therapies. The chapter on prognosis contains certain generally acceptable criteria in appraising the outcome in schizophrenia with or without the shock therapies.

Other important aspects are reviewed such as psychotherapy, dementia præcox in childhood, and miscellaneous studies. Under "psychosurgery" only prefrontal lobotomy is discussed briefly. The section on psychotherapy though brief is excellent.

Careful study of this excellent book would be profitable to all psychiatrists who wish to be informed as to the recent literature.

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Projective Techniques. By *John Elderkin Bell.* (New York: Longmans, Green and Co., 1948.)

This book attempts to be a general survey of projective techniques, a summarization of their literature, and a text usable as an "introductory manual" for students learning the methods. Whether these aims are compatible can be disputed, but within the limits of such a task a fairly good job has been done. The author treats the various methods in separate chapters, classifying all projective techniques under four main headings: word-association and related methods, visual stimulus techniques, expressive movement techniques, and techniques derived from play and drama. For each technique he describes the materials and procedures, the method of scoring and interpreting (including alternative procedures used by different workers, if any), and finally summarizes the data on reliability and validity. It must be seriously doubted whether the introductory manual idea has been achieved, since no one of the methods could be satisfactorily studied from this book. The summary of literature is rapid-fire, densely packed, and not particularly critical. Habits of methodological sophistication would not be demanded or engendered in the student by studying Bell's reviews. For example, in studies failing to control the age variable no stress is put upon this fact. As is usual, differences and trends are noted without much concern for overlap and for the practical value of a given trend. In a few cases relevant literature is missing from a context where it might be expected: *e. g.*, in treating of Rorschach reliability, the negative findings of Fosberg on distortion of protocol are cited, but not the positive results of Coffin. However, for the most part coverage is good and there is not any marked display of bias in any direction. The theoretical section is brief and quite disappointing, consisting of clichés such as "personality is a dynamic process" and an enunciation of basic theorems (sic!) such as ". . . . personality structure, as well as the influence of the field . . . . reveals itself in the behavior of the individual since behavior is functional." On the other hand, the general critical section and the proposals for research are good, and if taken seriously should help raise the level of scientific work in the field. For teaching purposes, it would have helped to present some case material so that the kind of clinical information actually contributed by each device, and the part it could play in concrete clinical decisions, might be clarified. On the whole, the book is a contribution. It could be used as a general text in a survey course where students are to be exposed to all the major methods but expected to really study only a few, for which other manuals would be needed. It can be recommended to psychiatrists-in-training who want to learn more about the psychologist's tools without spending much time at it; and it is a handy reference book for any psychologist in the clinical field, even if the experts on single techniques may find things to complain of.

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Psychopathology and Education of the Brain-Injured Child. By *Alfred A. Strauss and Laura E. Lehtinen.* (New York: Grune and Stratton, 1947.)

After reading this book two questions present themselves: (1) for whom was this book primarily intended; and (2) why isn't there more of it? Those acquainted with the published studies of the present authors and H. Werner in the field of the retarded brain-injured child will be grateful for this volume. It collates the separate reports and gives them a continuity and meaning that goes beyond the mere additive impression gained by reading the discrete articles.

With reference to the first question—to whom is this book addressed?—a perusal of the Contents indicates a partial answer. It would appear that Strauss and Lehtinen have attempted to reach as many different persons as possible, including the parent who could reasonably be expected to gain some insight into, and hope for, his child. The universal appeal of this book might easily

include: (1) the medical man, *i. e.*, the general practitioner, who is usually the first to give some confirmation of the parents' fears; (2) the clinical psychologist, who would find his interest whetted by the descriptions and interpretations of the psychological functioning of the brain-injured child as well as by the unique test devised by the authors; (3) the neurologist, who should read and accept the challenge of the authors to tease out with greater certainty the neurological pathology of the structure concomitant with, or causative of, aberrant function; and finally (4) the educator, who would be stimulated by the rationale and methodology of the education of the brain-injured child. In reaching for wide reader appeal, or perhaps in an effort to tell as much as possible, the book succeeds in covering a great deal but with too few details in spots. The well-documented bibliographic references to the authors' (and others') previously published research very adequately serves the purpose of informing the reader as to the sources where gaps may be filled in or where particular areas of interest may be further pursued.

The second question—why isn't there more of it?—is prompted by the understandable need for knowing more about the experiences of the authors with the encephalopathic child, for more detailed description of the writers' testing methods, their theoretical considerations, and reasons for the success and failure in the education of these physically and psychologically handicapped children.

Part 1, "Psychopathology" of the brain-injured child, is prefaced by the writers' orientation. The framework is organismic and is heavily saturated with Goldstein's "catastrophic reaction" and the concept of "driveness." There is early recognition of the difficulty of describing the injured organism holistically so that Strauss and Lehtinen admittedly confine themselves to specific aspects of the child's behavior.

The "Historical Review" of Chapter I is an excellent developmental précis of the theory of the retarded. On page 15 the authors raise the question: "What of the numerous children with no motor defect but with conspicuous lack of intelligence appearing together with a history of brain injury?" The ensuing 180 pages contain the answers. The second chapter on brain anatomy seems somewhat oversimplified but it does point up the important rôle of the brain in the psychological structure and function of the brain-injured personality.

The chapter describing the "Perception and Perceptual Disturbances of the Brain-Injured Child" is mainly devoted to the rationale, administration, and findings of the Marble Test used by the authors in their study of the performance of these children. Chapters IV, Thinking Disorders, and V, Behavior Disorders, emphasize the understanding of the brain-injured child's thought processes and social behavior. These two chapters develop the foundation for the pedagogic methodology discussed in Part 2. The chapters are fully illustrated with detailed case histories. The discussion of the developmental sequence of behavior in the normal and brain-injured child and the comparative studies of the behavior of the encephalopathic child with the psychoneurotic, mentally deficient, psychopathic, and schizophrenic child add materially to the value of this book.

In the chapter on "Testing the Brain-Injured Child" the authors could have elaborated on the techniques of *how* to test these children. It is readily admitted by anyone who has come in contact with the brain-injured that the accepted standard tests cannot be administered to them as they are to normal children. The reader approaches the section on "Standardized Tests and Qualitative Tests" and "The Rorschach Test and the Brain-Injured Child" with anticipation and hope of learning something of the special procedures to be utilized with these children. This information is not forthcoming beyond the authors' statements: "The testing of a child such as we have described is a wearing experience for the examiner. . . . ." (p. 100), and "In summary: with few exceptions there does not exist at this moment a pattern or type of response characteristic and specific for the brain-injured defective child on standardized tests of intelligence, academic achievement, and visuomotor performance" (p. 104). At least a challenge is offered to the clinical psychologist!

Part 2, "Education," discusses the general principles of education for the brain-injured and the specific methods of teaching the fundamentals—arithmetic, reading, and writing. This section is of utmost importance to the teacher of the handicapped. This is supplemented with an appendix by Mary A. Blair, Michigan State Supervisor of the Physically Handicapped, giving a detailed report of the training of a brain-injured deaf child.

For those whose interest lies in the field of developmental psychology—of the normal and especially the brain-injured—this book will go a long way toward meeting their needs. The book is an excellent introduction to the psychology of the brain-injured child.

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The Criminal and His Victim. By *Hans von Hentig.* (New Haven: Yale University Press, 1948.)

This book, another treatise on criminology, purports to give special consideration to "the crime provocative function of the victim." However, the material on the symbiotic rôle of the victim is scant and is scarcely more than would go into the writing of a magazine article. Although the book gives evidence of the erudition of its well-known author, it is on the whole very disappointing.

It is replete with interesting bits of information, *e. g.*, that Jewish Law classified tax collectors with robbers, that butchers were long excluded from serving as jurors in England, that 60% to 70% of fires in Germany were not accidental, that it is almost universally considered bad luck to marry in May, etc. Seven pages are devoted to a con-

sideration of the relationship of red hair to criminality.

The author seems to speak most authoritatively when he is analyzing the relative crime rates of urban and rural communities, those of the foreign and the native born, and the seasonal variations in crime rates. He seems far less competent in matters related to the biological sciences. He casually asserts in a footnote that "there is a probability that some acquired characteristics are passed on to subsequent generations"; he states that alcoholization cannot always be revealed post-mortem; that worry and apprehension affect the embryo, etc.

Von Hentig's greatest weakness is in the area of psychiatry. He speaks of dynamic psychiatry, but has obviously no knowledge nor understanding of it. His three chief psychiatric sources are Kraepelin, Ellis, and Lombroso. He seems to accept their antiquated dicta as pontifical pronouncements. His own statements on psychiatry seem, in the light of modern work, to be a kind of mumbo jumbo, *e. g.*, "Psychoses are, for the most part, diseases or derangements of some bodily process, which happen to affect the brain as the point of least resistance." . . . . "Matrimony, an integrated family group, or other closely knit groups are great dissemblers of insanity." . . . . "Moral imbecility is but one side of a polarity which includes moral oversensibility." . . . . "Such individuals as these suffer from an overproduction of compassionate emotions, an overstimulation of that part of our brain where altruism, helpfulness, sympathy and commiseration are located. Their morbid state is the reverse of moral invalidism." He states that in manic-depressive insanity "the mesencephalon is not injured, but other brain centers in which reintegration is easier. . . . . Epileptic insanity is a psychosis in which defective heredity, syphilis, rheumatism, diabetes, and other ailments are the predisposing conditions." He accepts the idea that periodic drinkers and hobos are often epileptics, that dementia præcox has a toxic origin, that Negroes have a relative immunity to the toxic action of alcohol, that the insanity rate is high among Jews, that emotional imbalance is general in the feebleminded, and that "psychopathic personalities are characterized by great dependency on weather and temperature." He says, "Psychopaths and the feebleminded are much more frequently victimized in some way or other than victimizing." He defines the feebleminded as "morally, emotionally, and volitionally defective persons who become included in this category as soon as the I.Q. or M.R. (Mental Ratio) falls below the age of nine." The author has a lamentable predilection to accept as his chief sources books and articles written more than a quarter of a century—in many cases more than a half century—ago. This is true not only in psychiatry. For instance in his discussion of unemployment he leans heavily on Drage's work published in 1894. For suicide statistics he goes to Bailey's publication in 1903.

This study may serve as a source book for those interested in finding certain facts and theories on criminality, but it does not merit the time required to read it. Before the Yale Press lends its imprint to a new edition it should call on the editorial services of a psychiatrist.

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METHODS OF PSYCHOLOGY. Edited by *T. G. Andrews*. (New York: Wiley, 1948.)

This book purports to fill "the need for greater emphasis on methodology in the training of students in psychology" (p. ix). Psychology has long been concerned that her sister sciences are dubious as to whether she really belongs in the family; the reading of this book by the nonpsychologist should convince him that there is considerable methodological sophistication among psychological researchers, and it should permit him to evaluate the bases for the psychologist's conclusions.

Since this is a book on methodology, the general plan has been to exclude as much discussion of experimental results and history as possible. To this end, there is a lucid introductory statement by the editor, defining the ground plan and logic of experimental method wherever found (Chap. I). There follows a series of 21 chapters, each concerned with the specific application and implementation of this basic method to as many areas (including conditioning, learning, memory, thinking, psychophysics, perception and sensation, animal behavior, motivation, feeling and emotion, action, neuropsychology, motor functions, intelligence, personality, clinical psychology, psychopathology, child psychology, social behavior). Each chapter is written by a specialist in his field.

It is curious that a book whose intent is exclusively methodological should be thus planned about subdivisions of psychology, since these subdivisions are determined on the basis of content, not method. Some of these very competent authors have tried to restrict their discussions to technique, but most have included a good deal of factual data anyway. The fact that consideration of experimental results has been included actually serves to make these chapters of interest and usefulness to a broader readership than would a book truly restricted to technique.

History reveals itself in that one-third of the chapters refer to matters of sensation and perception, psychology's first concern. (There is even one chapter on the skin senses.) This is probably a proper ratio of techniques, historically, but certainly far less than one-third of psychological experiments today are in these areas. The reader unacquainted with what the modern psychologist is up to would receive a distorted notion of emphasis.

The reader of a book by many authors is probably prepared for unevenness of quality and style. This book is about average in this respect. A real attempt seems to have been made to avoid repetition. Each chapter may be read alone, an advantage of the cafeteria method for the reader whose interests are specialized.

Each chapter has an extensive bibliography, including books and journal articles. There are both subject and author indexes.

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PSYCHOLOGIST UNRETIRED: THE LIFE PATTERN OF LILLIEN JANE MARTIN. By *M. A. DeFord.* (Stanford, Calif.: Stanford University Press, 1948.)

Occasionally in the history of science the biography of an individual is at the same time the biography of a new field. So it is with the life story of Lillien Jane Martin, which contains also the birth, the early development, and the mature fruition of professional old-age counselling. This brief literary biography, written in somewhat idealized fashion by a prominent San Francisco author, makes it plain that Dr. Martin's establishment of the first center for counselling the aged was essentially the outgrowth of the personal problems and philosophy of its founder.

Dr. Martin's life spanned a 91-year period during which many important changes occurred in the education of women. She herself both reflected and hastened these changes. She introduced laboratory science courses into girls' high schools, took her doctorate in psychology at Göttingen at a period when women students were unwelcome there, developed the psychological laboratory at Stanford University, and served as acting chairman of the Stanford psychology department. At the time of her retirement from her Stanford professorship, she was the author of a number of experimental papers, she held an honorary doctorate from Bonn, and she was starred in *American Men of Science.* Retirement brought her inevitable isolation, loneliness, and insignificance—but only briefly. For she quickly fashioned, from her own reactions to ageing, first a philosophy and then a technique of counselling the aged, which she used successfully with clients until her death 27 years later.

The "pattern" of so long and productive a life is not simple to trace. DeFord, the biographer, in easy and often graceful style, follows out the main theads that hold the pattern together. Dr. Martin was the daughter of a dominant, undemonstrative mother and a "clever but irresponsible" father; she expressed her feelings rarely, valued friendship above affection, and maintained strongly feminist attitudes. Reared by a mother who exchanged the rôle of housewife for a career, Dr. Martin became a person of great adaptability, a world traveller, a woman who several times sharply altered her own life pattern. From her family life and her teaching experiences she constructed a philosophy of *participation,* which she expressed equally in her self-attitudes, her counselling techniques, and her political activities. The pattern that emerges from the biographer's analysis is that of an able woman whose personal philosophy, intellectually derived and intellectually applied, made her a "highly conscious planner" of her own life, and an effective catalyst in the lives of those who sought her help.

This biography makes a dual contribution to psychiatry. It provides a rationale for the Martin technique of old-age counselling, to which participation and self-acceptance are central. It also affords an opportunity for a further analysis of the factors that led, in one life, to tremendous productivity and personal satisfaction. Both contributions represent legitimate and challenging aspects of contemporary behavior pathology.

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SOCIAL ADJUSTMENT IN OLD AGE: A RESEARCH PLANNING REPORT. By *Otto Pollak.* (New York: Social Science Research Council, 1948—Bulletin 59.)

This small volume is a reintegration of and supplement to a previous report on social adjustment in old age. It provides a provocative basis for future investigation into the many problems faced by society because of an increasing number of people reaching later maturity. The clinical psychiatrist, interested as he is in the emotional problems of the individual, sometimes may not appreciate fully the significance of the broad socio-economic factors playing important rôles in such a person, and this monograph clearly emphasizes these.

A worthy attempt is made by the author to define what is meant by old age and he emphasizes that "the popular stereotype of old age as a unitary period is misleading and so is the conception of the aged personality as a rigid and static configuration of traits. Social scientists therefore should define old age as an advanced but nonetheless continuing process of human development and gauge its impact at consecutive stages of the variations implied." A chapter on the demographic basis for the social phenomena involved provides important statistics concerning the numbers of the aged, their future trend, sex distribution, marital status, geographic distribution, living arrangements, and employment. The sections on "A Proposed Frame of Reference" and "Psychological Analysis" should be of particular interest to the psychiatrist, emphasizing as they do that the emotional problems of the aged are like all psychological problems, those of adaptation to a changing functional equilibrium within the person as well as a changing attitude to him from his environment. Old age problems arise not only because of changes in physical and mental capacities, but also because of changes in social opportunities and expectations.

Following proposed general plans for studying the aging individual's needs, capacities, and predispositions, an effort is made to correlate these with plans of study of the rôles the aged play in the family, in politics, in religious groups, and in the economic world, especially in terms of opportunities provided for him for making a living, retirement, recreation, and education.

The report is concluded by a short statement on "Sampling for Old Age Research," by Frederick F.

Stephan, and a selected bibliography. This is a timely bulletin that should stimulate considerable interest, and which suggests plans for future investigation into various aspects of gerontology. It is remarkably clear, concise, and thought-provoking.

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GENIALE MENSCHEN (MEN OF GENIUS). By *Ernst Kretschmer*. Fourth edition. (Berlin: Springer-Verlag, 1948.)

"This book," writes Professor Kretschmer, "concerns itself solely with the personality of genius, with the laws of its biological origin and the psychology of its inner makeup and its driving forces."

The first edition appeared in 1929 and was based largely on lectures given 10 years earlier. The present edition contains new material from the study of twins, on heredity in the families of Schiller and Haydn, and on the pathological phases in the life of Goethe. Of special interest is the collection of 81 portraits of men of genius discussed in the text.

Kretschmer carefully defines genius as a strictly individual and unusual personality type, of exceptional endowment, determined by genetic laws, a creator—not merely a transmitter—of new values. Too often a note of tragedy or bitter misunderstanding characterizes the social relationships of the man of genius.

He discounts the idea of necessary relationship between mental disease and genius, although recognizing the fact that mental disorders, especially border psychopathic conditions, are decidedly more frequent among men of genius than in the population at large. It is also noteworthy that severely morbid family histories are startlingly frequent in the cases of the greatest geniuses, *e. g.*, Goethe, Byron, Beethoven, Bach, Michelangelo, Feuerbach.

While genius and mental diseases are not to be equated, the author uses the word "dæmonic" to represent the exceptional psychic quality of genius and states that dæmonic and psychopathologic factors are hardly to be distinguished.

A striking comparison is between the psychopathic or mentally ill revolutionaries and other social disturbers on the one hand and pathogenic microbes on the other. If the social organism is relatively sound and stable, the abnormal characters remain harmless; but when environmental conditions deteriorate the human microbes acquire intensified virulence and may cause mass infection among the people. "Psychopaths are always with us. In times of calm we certify them; in fevered times they dominate us."

Kretschmer discusses from various points of view the concurrence of genius and psychopathological traits. When the abnormal, exceptional, or dæmonic elements appear in personalities otherwise sound and conforming in general to conventional norms, the concurrence of the two qualities may lead to great achievement, as in the cases of Bismarck and Goethe, both of whose family histories showed marked psychopathologic taint. The early development of Bismarck foreshadowed an uncertain future. As student he made the statement: "Ich werde entweder der grösste Lump oder der erste Mann Preussens." Goethe, whose sister suffered severe attacks of mental illness, was of well-marked cyclothymic temperament. His depressive phases were unproductive, almost all his best work being associated with phases of elevated affect such as one sees in hypomanic states. The depression with suicidal urges reflected in Werther Goethe himself described as a pathological condition. Eckermann relates further that Goethe was subject to a seasonal depression "each year for weeks just before the shortest day."

Throughout history and literature Kretschmer finds evidences of genius, linked with psychic deviations, abnormalities, and pathology, and resulting in heroic acts and immortal productions in the arts. He traces certain compulsion neuroses to abnormalities in primary biologic drives and particularly to sadistic-masochistic impulses; and sees a connection between compulsion neurosis and that morbid sense of duty which causes certain anxious souls to make voluntary martyrs of themselves. The pathological drives in the personality of John Calvin and many others are explored.

Referring to his book, "Physique and Character," the author indicates certain correspondences not only between body form and psychosis but also in general between basic personality characteristics and physical makeup—a real holistic viewpoint. He records as axiomatic that "genius as such is born, ... that exceptional psychic achievement is only possible on the basis of special hereditary traits, which personal efforts and favorable environment may enhance and improve but cannot replace."

Kretschmer devotes a long chapter to "Genius and Race" and disposes conclusively of fact and fancy in racist theories. He elaborates further the periodic expression of genius, as in Goethe, its manifestations at different life stages, and in relation to changes in endocrine activity.

In discussing psychological differences in men and women, particularly with regard to great achievements, the author offers some corrective comments on an essay of Möbius, "Ueber den physiologischen Schwachsinn des Weibes," that created a considerable furor half a century ago, and of which the arresting but somewhat misleading title had better be left in the original German.

Kretschmer writes brilliantly with remarkable richness of vocabulary, and his book throws much light on the mutual relationships of (1) "normal" personality, (2) physical makeup and blood chemistry, (3) genius, (4) mental abnormality and disorder.

C. B. F.